Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

Physician-Related Services

Billing Instructions

November 2001

Copyright Disclosure

About this publication

This publication supersedes all previous MAA RBRVS Billing Instructions.

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Washington State Department of Social and Health Services
November 2001

Received too many billing instructions?
Too few?
Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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A provider may contact MAA's toll-free lines for questions regarding MAA programs. However, MAA's response is based solely on the information provided to the representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern MAA's programs. [WAC 388-502-0020(2)].

Where do I call for information on becoming a DSHS provider, submitting a change of address or ownership, or to ask questions about the status of a provider application?

Call the toll-free line:
(866) 545-0544

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9248
Olympia WA 98507-9248

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

How do I obtain copies of billing instructions or numbered memoranda?

Check out our web site at:
http://maa.dshs.wa.gov

Or write/call:
Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800) 562-6188

Where do I call if I have questions regarding…

Policy, payments, denials, or general questions regarding claims processing, Healthy Options?

Provider Relations Unit
(800) 562-6188

Private insurance or third party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

Electronic Billing?

Write/call:
Electronic Billing Unit
PO Box 45512
Olympia, WA 98504-5512
(360) 725-1267

Other Important Numbers

Client Assistance/
Brokered Transportation Hotline (Clients Only) 1-800-562-3022

Disability Insurance..... 1-800-562-6074

Durable Medical Equipment (DME)/Prosthetics
Authorization..... 1-800-292-8064

Fraud Hotline..... 1-800-562-6906

Healthy Options Enrollment..... 1-800-562-3022

Acute PM&R Authorization FAX..... 1-800-634-1398

Pharmacy Authorization **(Providers Only)**..... 1-800-848-2842

Provider Inquiry Hotline **(Providers Only)**..... 1-800-562-6188

Provider Enrollment 1-866-545-0544

Telecommunications Device For The Deaf (TDD)..... 1-800-848-5429

Third-Party Resource Hotline 1-800-562-6136

Ambulance Transportation/Hospice Authorization 1-800-624-4793

TAKE CHARGE..... 1-800-770-4334

Provider Field Representatives

(360) 725-1024
(360) 725-1027
(360) 725-1022
(360) 725-1023

MAA Billing Instructions

Access to Baby & Child Dentistry
Acute Physical Medicine & Rehabilitation
Adult Day Health
Ambulatory Surgery Center
Births in Birthing Centers
Blood Bank Services
Chemical Dependency
Chemical-Using Pregnant (CUP) women
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Fluoride Varnish Supplements
General Information Booklet
Ground/Air Ambulance Medical Transportation
EPSDT
Healthy Options Registered Health Carriers
Hearing Aids and Services
HIV/AIDS Case Management
Home Health Services
Hospice
Hospital-Based Inpatient Detoxification
Hospital Inpatient
Hospital Outpatient
Indian Health Services
Infusion/Parenteral Therapy
Interpreter Services
Involuntary Treatment Act (I.T.A.) Transp.
Kidney Centers
Maternity Case Management
Maternity Support Services
Medical Nutrition
Medical Nutrition Therapy
Neurodevelopmental Centers
Nondurable Medical Equipment & Supplies
Nurse Delegation
Nursing Facilities
Occupational Therapy
Oxygen/Respiratory Therapy
Physical Therapy
Physician-Related Services (RBRVS)
Planned Home Births
Prenatal Diagnosis Genetic Counseling
Prescription Drug Program
Private Duty Nursing Services
Prosthetic & Orthotic Devices
Psychologist
Registered Nurse First Assistant (For Cesarean Sections)
Rural Health Clinics
School Medical Services
Speech/Audiology Program
TAKE CHARGE
Vision Services
Wheelchairs/Durable Medical Equipment & Supplies

For more information on MAA billing instructions, call 1-800-562-6188.

As these billing instructions are updated, they will be loaded onto our Web site: http://maa.dshs.wa.gov, Billing Instructions link.

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Definitions

The sections defines terms and acronyms used in these billing instructions.

Acquisition Cost – The cost of an item excluding shipping, handling, and any applicable taxes. [WAC 388-531-0050]

Acute Care – Care provided for clients who are not medically stable. These clients require frequent monitoring by a health care professional in order to maintain their health status (WAC 248-27-015). [WAC 388-531-0050]

Add-on procedure(s) – Secondary procedure(s) performed in addition to another procedure. [Refer to WAC 388-531-0050]

Admitting Diagnosis – The medical condition responsible for a hospital admission, as defined by ICD-9-CM diagnostic code. [WAC 388-531-0050]

Assignment – A process in which a doctor or supplier agrees to accept the Medicare program's payment as payment in full, except for specific deductible and coinsurance amounts required of the patient.

Authorization – MAA official approval for action taken for, or on behalf of, an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

Authorization Number – A nine-digit number assigned by MAA that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

Authorization Requirement – In order to obtain authorization for some services and equipment, you must provide proof of medical necessity. Each request must include a complete, detailed description of the diagnosis and/or any disabling conditions justifying the need for the equipment or the level of service being requested.

Base anesthesia units (BAU) – A number of anesthesia units assigned to a surgical procedure that includes the usual preoperative, intra-operative, and postoperative visits. This includes the administration of fluids and/or blood incident to the anesthesia care, and interpretation of noninvasive monitoring by the anesthesiologist. [WAC 388-531-0050]

Bundled services – Services integral to the major procedures that are included in the fee for the major procedure. Bundled services are not reimbursed separately. [WAC 388-531-0050]

By Report (BR) – A method of reimbursement in which MAA determines the amount it will pay for a service that is not included in MAA's published fee schedules. MAA may request the provider to submit a "report" describing the nature, extent, time, effort, and/or equipment necessary to deliver the service. [WAC 388-531-0050]

Client – An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) – A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office (CSO) – An office of the department that administers social and health services at the community level. [WAC 388-500-0005]

Core Provider Agreement – The basic contract that MAA holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

Covered service – A service that is within the scope of the eligible client's medical care program, subject to the limitations in WAC 388-531 and other published WAC. [Refer to WAC 388-531-0050]

Current Procedural Terminology (CPT™) – A systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians and other practitioners who provide physician-related services. CPT is copyrighted and puslied annually by the American Medical Association. [WAC 388-531-0050]

Department – The state Department of Social and Health Services [WAC 388-500-0005]

Early and Periodic Screening, Diagnosis, And Treatment (EPSDT) – Formerly known as the "healthy kids" program, means a program providing early periodic screening, diagnosis and treatment to persons younger than 21 years of age who are eligible for Medicaid or the children's health program. [Refer to WAC 388-500-0005]

EPSDT Provider – (1) A physician, advanced registered nurse practitioner (ARNP), or public health nurse certified as an EPSDT provider; ***or*** (2) a dentist, dental hygienist, audiologist, or optometrist who is an enrolled Medical Assistance provider and performs all or one component of the *EPSDT* screening.

Emergency Services – Services provided for care required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the client's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Explanation of Benefits (EOB) – A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Expedited Prior Authorization (EPA) – A process designed by MAA to eliminate the need for written prior authorization (see definition for "prior authorization"). MAA establishes authorization criteria and identifies the criteria with specific codes. If the provider determines the client meets the criteria, the provider creates the authorization number using the specific MAA-established codes.

Fee-for-service – The general payment method MAA uses to reimburse providers for covered medical services provided to medical assistance clients when those services are not covered under MAA's Healthy Options program or Children's Health Insurance Program (CHIP) programs. [WAC 388-531-0050]

Informed Consent – That an individual consents to a procedure after the provider who obtained a properly completed consent form has done all of the following:

(1) Disclosed and discussed the client's diagnosis; and
(2) Offered the client an opportunity to ask questions about the procedure and to request information in writing; and
(3) Given the client a copy of the consent form; and
(4) Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. Chapter IV 441.257; and
(5) Given the client oral information about all of the following:
    (a) The client's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure; and
    (b) Alternatives to the procedure including potential risks, benefits, and consequences; and
    (c) The procedure itself, including potential risks, benefits, and

[WAC 388-531-0050]

Inpatient Hospital Admission – An acute hospital stay for longer than 24 hours when the medical care records shows the need for inpatient care beyond 24 hours. All admissions are considered inpatient hospital admissions, and are paid as such, regardless of the length of stay, in the following circumstances:

(1) The death of a client;
(2) Obstetrical delivery;
(3) Initial care of a newborn; or
(4) Transfer to another acute care facility.

[WAC 388-531-0050]

Limitation Extension – A process for requesting and approving reimbursement for covered services whose proposed quantity, frequency, or intensity exceeds that which MAA routinely reimburses. Limitation extensions require prior authorization. [WAC 388-531-0050]

Managed Care – A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. [WAC 388-538-050]

Maximum Allowable Fee – The maximum dollar amount that MAA reimburses a provider for specific services, supplies, and equipment. [WAC 388-531-0050]

Medical Assistance Administration (MAA) – The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medicaid – The state and federally-funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Consultant – Physicians employed by MAA who are authorities on the medical aspects of the Medical Assistance program. As part of their responsibilities, MAA medical consultants:

- Serve as advisors in communicating to the medical community the scope, limit, and purpose of the program.
- Assist in the development of MAA medical policy, procedures, guidelines, and protocols.
- Evaluate the appropriateness and medical necessity of proposed or requested medical treatments in accordance with federal and state law, applicable regulations, MAA policy, and community standards of medical care.
- Serve as advisors to MAA staff, helping them to relate medical practice realities to activities such as claims processing, legislative requests, cost containment, and utilization management.
- Serve as liaisons between MAA and various professional provider groups, health care systems (such as HMOs), and other State agencies.
- Serve as expert medical and program policy witnesses for MAA at fair hearings.

Medical Identification Card – The form DSHS uses to identify clients of medical programs. These cards are good only for the dates printed on them. Clients will receive a Medical Identification card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards and were formerly called medical coupons or MAID cards.

Medically Necessary – A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medical Operations, Division of (DMO) – Formerly know as DHSQS – The division within MAA responsible for promoting and improving the quality of health care consistent with community practice standards and including access, cost effectiveness, coordination and accountability to produce positive client outcomes.

Medicare – The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

Newborn – To assist providers in billing CPT codes with "newborn" in the description, MAA defines newborns as younger than 1 year of age.

Noncovered Service or Charge – A service or charge not reimbursed by the department.

Patient Identification Code (PIC) – An alphanumeric code that is assigned to each Medicaid client and which consists of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Pound Indicator (#) – A symbol (#) indicating a CPT procedure code listed in MAA fee schedules that is not covered.

Prior Authorization – Written MAA approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. *Expedited prior authorization and limitation extensions are forms of prior authorization.*

Professional Component – The part of a procedure or service that relies on the provider's professional skill or training, or the part of that reimbursement that recognizes the provider's cognitive skill. [WAC 388-531-0050]

Program Support, Division of (DPS) – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Family Planning Services;
- Administrative Match Services to Schools and Health Departments;
- Managed Health Care Contracts;
- Provider Enrollment/Relations; and
- Regulatory Improvement.

Provider or Provider of Service – An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

Relative Value Unit (RVU) – A unit that is based on the resources required to perform an individual service. RBRVS RVUs are comprised of three components – physician work, practice cost, and malpractice expense.

Remittance And Status Report (RA) – A report produced by MAA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Resource based relative value scale (RBRVS) – A scale that measures the relative value of a medical service or intervention, based on the amount of physician resources involved. [WAC 388-531-0050]

RBRVS Maximum Allowable Amount – The Medicare Fee Schedule relative value unit, multiplied by the statewide geographic practice cost index, times the applicable conversion factor.

Revised Code of Washington (RCW) – Washington State laws.

State Unique Procedure Code(s) – Procedure codes established by the Reimbursement Steering Committee (RSC) to define services or procedures not continued in CPT or HCPCS level II. [WAC 388-531-0050]

Technical Component – The part of a procedure or service that relates to the equipment set-up and technician's time, or the part of the procedure and service reimbursement that recognizes the equipment cost and technician time. [WAC 388-531-0050]

Third Party – Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. [WAC 388-500-0005]

Title XIX – The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. [WAC 388-500-0005]

Usual & Customary Fee – The rate that may be billed to the department for a certain service or equipment. This rate may not exceed:

1) The usual and customary charge that you bill the general public for the same services; or
2) If the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) – Codified rules of the State of Washington.

Introduction

Procedure Codes

The following types of procedure codes are used within this Physician-Related Services Billing Instruction:

- Physician's Current Procedure Terminology (CPT™);
- Level II Health Care Financing Administration's Common Procedure Coding System (HCPCS); and
- State-Unique (Level III).

Procedures performed must match the description and guidelines from the most current CPT or HCPCS manual for all MAA-covered services. **Due to copyright restrictions, MAA publishes only short CPT descriptions. To view the full CPT description, please refer to your current CPT manual.**

MAA specifies in this billing instruction:

- When MAA's guidelines differ from CPT; and
- When state-unique codes are appropriate and what the descriptions are.

Note: MAA adopts Medicare's guidelines and policies whenever possible.

Diagnosis Codes

MAA uses ICD-9-CM codes for physician-related services. Providers are required to use the code of the highest specificity (5 digit codes) from the ICD-9-CM whenever possible and accurate.

MAA does not cover the following diagnosis codes:

- E codes (Supplementary Classification);
- M codes (Morphology of Neoplasms); and
- Most V codes.

MAA reimburses providers for only those procedure codes and diagnosis codes that are within their scope of practice.

Noncovered Services

Procedures that are noncovered are noted with a # indicator in the Maximum Allowable column on the free schedule.

If a client has extenuating medical circumstances not covered under the client's MAA program that the medical provider feels MAA should take into consideration for coverage, the provider must submit a written request to MAA for an Exception to Rule (ETR). A sample form is located on page I3. You may use the form or at least submit equivalent information to MAA at the address listed below.

Send your written requests to:

ATTN: Medical Request Coordinator
Medical Operations, Medical Assistance Administration
PO Box 45506
Olympia, Washington 98504-5506

The following are examples of administrative costs and/or services not covered by MAA:

- Missed or canceled appointments;
- Mileage
- Take-home drugs;
- Educational supplies or services;
- Copying expenses, reports, client charts, insurance forms
- Service charges/delinquent payment fees;
- Telephoning for prescription refills; and
- Other areas as specified in this fee schedule.

MAA does not reimburse for services performed by any of the following practitioners [WAC 388-531-0250(2)]**:**

- Acupuncturists;
- Naturopaths;
- Homeopathists;
- Herbalists;
- Masseurs, masseuses;
- Christian Science practitioners or theological healers;
- Counselors (i.e., M.A. and M.S.N.);
- Sanipractors;
- Those who have a master's degree in social work (M.S.W.) except those employed by an FQHC; or
- Any other licensed or unlicensed practitioners not otherwise specifically provided for in WAC 388-502-0010; or
- Any other licensed practitioners providing services which the practitioner is not:
  (i) Licensed to provide; and
  (ii) Trained to provide.

Clients Enrolled in Managed Health Care

Many MAA clients are enrolled in a managed care program called Healthy Options. These clients have an HMO identifier in the HMO column on their DSHS Medical ID card. They will also receive an ID card from the managed care plan with whom they are enrolled. Clients enrolled in Healthy Options must obtain most of their services from their designated plans.

Note: Client's enrollment can change monthly. Prior to serving a Healthy Options client, make sure you received approval from <u>both</u> the plan and the client's PCP, if necessary.

Send claims to the client's managed care plan for payment. Call the client's HMO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in the <u>General Information Booklet</u> and WAC 388-87-010.

By Report (BR)

MAA may require a special report for certain services provided to MAA clients to determine whether the procedure is indeed necessary. These services are identified by a **BR** (By Report) in the procedure code listings in this manual. This special report must include an adequate definition or description of the nature, extent, and need for the procedure, including the time, effort, and equipment necessary. You may also be required to provide additional information.

Conversion Factors

These conversion factors multiplied by the Relative Value Units (RVUs) establish the rates in this fee schedule.

	7/1/96	7/1/97	7/1/98	7/1/99	7/1/00	7/1/01	7/1/02
Maternity	$45.07	$43.34	$43.19	$44.20	$45.33	$45.34	$45.59
Anesthesia	$12.63	$12.75	$12.75	$12.96	$15.10	$15.49	$15.70
Children's Primary Health Care	$43.60	$40.77	$39.11	$37.49	$35.89	$36.52	$35.62
Adult Primary Health Care	$27.33	$24.86	$23.67	$22.47	$21.17	$21.27	$20.44
All Other Procedure Codes	$23.04	$22.25	$22.27	$21.93	$22.37	$22.41	$22.75
Clinical Lab Multiplication Factor			.667	.689	.694	.720	.719

Correct Coding Initiative

Beginning in 2002, MAA is evaluating and implementing Medicare's Correct Coding Initiative (CCI) policy. This policy was created by the Centers for Medicare and Medicaid Services (CMS) to promote national correct coding methodologies. CCI will assist MAA in controlling improper coding that may lead to inappropriate payment. MAA will base coding policies on the American Medical Association's Current Procedural Terminology (CPT) manual, national and local policies and edits, coding guidelines developed by national professional societies, the analysis and review of standard medical and surgical practices, and review of current coding practices. These correct coding policies do not necessarily supercede any other specific MAA coding, coverage, or payment policies, unless specifically stated.

Programs (Guidelines/Limitations

Office and Other Outpatient Services

[Refer to WAC 388-531-0950]

In addition to those services listed in the fee schedule, the following limitations apply:

MAA reimburses for:

- One office or other outpatient call per noninstitutionalized client, per day for an individual physician (except for call-backs to the emergency room per WAC 388-531-0500).

  ✓ Certain procedures are included in the office call and cannot be billed separately. See Section K.

  Example: Ventilation management (CPT codes 94656, 94657, 94660, and 94662) is not reimbursed separately **when billed in addition to** an Evaluation and Management (E&M) service, even if the E&M service is billed with modifier 25.

  ✓ Bill the appropriate level of E&M *history and physical* (H&P) **procedures prior to performing** dental surgery in an outpatient setting. For Healthy Options clients, bill H&P claims to MAA as fee-for-service and use the appropriate ICD-9-CM dental diagnosis code.

- Two physician calls per month for a client residing in a nursing facility or an intermediate care facility.

- One physical examination per client, per year for Division of Developmental Disability clients only. See state-unique procedure code 0310M, page J109.

Children's Primary Health Care (CPT codes 99201-99215)

- MAA pays a higher reimbursement rate for primary health care performed in the office setting (CPT codes 99201-99215) for children 20 years of age and younger. These are the only services that will be reimbursed at the higher rate.

- If a child who is younger than one year of age **has not been issued** an individual Patient Identification Code (PIC), use the mother's or the father's PIC, and put a "B" in *field 19* on the HCFA-1500 claims form. **In addition, you must add modifier 1C only to CPT codes 99201-99215**, in order for the service to be reimbursed at the higher fee. Newborns born to managed care mothers are covered by the managed care plan.

Hospital Inpatient and Observation Care Services

(CPT codes 99217-99239)

[Refer to WAC 388-531-0750]

MAA will reimburse:

- One inpatient hospital call per client, per day for the same or related diagnosis. If the call is included in the global surgery reimbursement, MAA does not reimburse separately. (See the Surgical Services Section, page F10 for information on global surgery policy.)

- Professional inpatient services (CPT codes 99221-99223) during the follow-up period **only if** they are performed on an emergency basis and are unrelated to the original surgery. Use modifier 24 to indicate that the service is unrelated to the original surgery.

  Note: CPT codes 99221-99223 are not payable for scheduled hospital admissions during the follow-up period without a modifier 24.

- A hospital admission (CPT codes 99221-99223) billed by a psychiatrist in combination with one of the following:

  ✓ A psychiatric diagnostic or evaluative interview examination (90801); or
  ✓ For children 20 years of age and younger, an interactive psychiatric diagnostic interview exam (CPT code 90802).

MAA will not reimburse:

- A hospital admission (CPT codes 99221-99223) **and** a planned surgery when billed in combination. The hospital admission is already included in the global fee for surgery.

- For a physician to appropriately report CPT codes 99234 through 99236, the patient must be an inpatient or an observation care patient for a minimum of 8 hours on the same calendar date.

Other Guidelines:

- When the patient is admitted to observation status for less than 8 hours and is discharged on the same date, the physician must use CPT codes 99218 through 99220 and no discharge code must be reported.

- When patients are admitted for observation care and are discharged on a different calendar date, the physician must use CPT codes 99218 through 99220 and CPT observation discharged code 99217.

- When patients qualify as an inpatient hospital admission and are discharged on a different calendar date, the physician must use CPT codes 99221 through 99233 and CPT hospital discharge day management code 99238 or 99239.

- When patients qualify as an inpatient hospital admission and discharge on the same calendar date, CPT codes 99221 through 99223 must be used for the admission service, and the hospital discharge day management service must not be billed.

- The physician must satisfy the documentation requirements for both admission to and discharge from inpatient or observation care to bill CPT codes 99234, 99235, or 99236. The length of time for observation care or treatment status must also be documented.

Emergency Physician-Related Services **(CPT codes 99281-99285)**

[Refer to WAC 388-531-0500]

- For services performed by the physician assigned to, or on call to, the emergency department, bill MAA using CPT codes 99281 through 99285.

  Note: For multiple emergency room (ER) calls on the same day, with related diagnoses, you **must** indicate the time(s) of the additional call(s) on the claim form.

- MAA does not reimburse emergency room physicians for hospital admission charges (e.g., CPT codes 99221-99223) or additional service charges (e.g., CPT codes 99050, 99052, or 99054).

- Physicians who perform emergency room services must bill MAA for surgical procedures without modifier 54.

- Physicians who provide only the follow-up services for minor procedures performed in emergency departments must bill the appropriate level of office visit code without modifier 55.

End-Stage Renal disease (ESRD)

(CPT codes 90935, 90937, 90945, and 90947)

- Reimbursement is limited to one dialysis procedure code per day.

- Payment for dialysis (CPT codes 90935, 90937, 90945, and 90947) includes reimbursement for the following Evaluation and Management (E&M) services performed on the same day:

  ✓ CPT codes 99231-99233; and
  ✓ CPT codes 99261-99263.

- Separate reimbursement is allowed for the following procedure codes when they are provided on the same date of service as an inpatient dialysis service (CPT codes 90935, 90937, 90945, and 90947):

  ✓ Initial hospital visit (CPT codes 99221-99223);
  ✓ Initial hospital consultation (CPT codes 99251-99255); and
  ✓ Hospital discharge service (CPT code 99238).

- If E&M service is unrelated to dialysis procedure, bill E&M service with the unrelated diagnosis and modifier 25.

Critical Care (CPT 99291 and 99292)

[Refer to WAC 388-531-0450]

Critical care is performed in a critical care area of a hospital, such as a(n):

- Coronary care unit;
- Intensive care unit;
- Respiratory care unit; or
- Emergency care facility.

Critical care includes:

- The care of critically ill clients in a variety of medical emergencies that require the constant attention of the physician (e.g., cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, and critically ill neonate);

- Cardiopulmonary resuscitation and a variety of services attendant to this procedure as well as other acute emergencies.

  Note: Surgery, stand-by, or lengthy consultation on a stable client does not qualify as critical care.

MAA will reimburse:

- A maximum of 3 hours of critical care per client, per day.

- The attending physician(s) for inpatient critical care who assume(s) responsibility for the care of a client during a life-threatening episode.

- More than one physician if the services provided involve multiple organ systems (unrelated diagnosis). However, in the emergency room, payment for critical care services is limited to one physician.

The following are the services (with their corresponding CPT codes) that are included in reporting critical care. Do not bill these separately:

- The interpretation of cardiac output measurements (93561-93562)
- Chest x-rays (71010, 71015, and 71020)
- Blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data) (99090)
- Gastric intubation (43752 and 91105)
- Temporary transcutaneous pacing (92953)
- Ventilator management (94656-94657, and 94660-94662)
- Vascular access procedures (36000, 36410, and 36600)
- Blood draw for specimen (36415 and 36540)
- Pulse oximetry (94760-94762)

Physician Standby Services (CPT code 99360)

[Refer to WAC 388-531-1250]

MAA reimburses physician standby services (CPT code 99360) when:

- Used to report physician standby services requested by another physician and involving prolonged physician attendance without direct (face-to-face) patient contact.

  Note: The standby physician cannot provide care or service to other patients during this period.

- Used to report the total duration of time spent. Standby service of less than 30 minutes is not reimbursed under any circumstances.

  Note: Subsequent periods of physician standby, after the first 30 minutes, are reimbursable only when a full 30 minutes of standby is provided for each unit billed. Round down all fractions of a 30-minute time unit.

Physician standby services (CPT code 99360) are not reimburse when:

- The period of standby ends with the performance of a procedure subject to a "global surgical reimbursement" by the physician who was on standby. Refer to page F10.

- Billed in addition to any other procedure code, with the exception of CPT codes 99431 and 99440, or when it results in an admission to a neonatal intensive care unit (CPT 99295) on the same day.

- Standby service of less than 30 minutes.

Prolonged Services (CPT codes 99354-99357)

[Refer to WAC 388-531-1350]

MAA reimburses for prolonged services:

- Up to three hours per client, per diagnosis, per day.

  Note: The time counted toward payment for prolonged E&M services includes only direct face-to-face contact between the physician and the patient (whether the services was continuous or not).

- Only when the physician provides and bills one of the procedure codes listed below for the client on the **same day** and on the **same claim**:

Prolonged CPT Code	Other CPT Code(s) Required on Same Day, Same Claim
99354	99201-99215, 99241-99245, 99301-99350
99355	99354 *and* one of the E&M codes required for 99354
99356	99221-99233, 99251-99255, 99261-99263
99357	99356 *and* one of the E&M codes required for 99356

Osteopathic Manipulative Therapy (CPT codes 98925-98929)

[Refer to WAC 388-531-1050]

MAA will reimburse:

- Ten (10) osteopathic manipulations per client, per calendar year.
- Osteopathic Manipulative Therapy (OMT) services only when provided by an osteopathic physician licensed under chapter 18.71 RCW.

  Note: Under the CPT codes, **body regions** are defined as:

  - head
  - cervical
  - thoracic
  - lumbar
  - sacral
  - pelvic
  - lower extremities
  - upper extremities
  - rib cage
  - abdomen
  - viscera

  These codes ascend in value to accommodate the additional body regions involved. Therefore, only **one code is payable per treatment**.
  For example, if three body regions were manipulated, one unit of CPT code 98926 would be payable.

- An E&M service will be reimbursed in addition to the OMT under one of the following three circumstances:

  ✓ When a physician diagnoses the condition requiring manipulative therapy and provides the therapy during the same visit;
  ✓ When the existing related diagnosis or condition fails to respond to manipulative therapy or the condition significantly changes or intensifies, requiring E&M services beyond those considered included in the manipulation codes; or
  ✓ When the physician treats the patient for a condition unrelated to the condition requiring manipulative therapy during the same encounter.

  To be reimbursed for the E&M service, use modifier 25 if the E&M service meets one of the above circumstances. Justification for the E&M and OMT service must be documented and retained in the provider's office for review.

MAA does <u>not reimburse</u>:

- Physical therapy services performed by osteopathic physicians.

Newborn Care **(CPT codes 99431-99440)**

To assist providers in billing CPT codes with "newborn" in the description, MAA defines newborns as younger than one year of age.

MAA will reimburse:

- **Newborn evaluations:** (CPT codes 99431-99433)
  Note: 99432 is payable only for Home Births.
  Note: Use 99435 only for newborns evaluated and discharged on the same date.

- **Discharge services:**
  Newborn admitted and discharged with different dates (CPT code 99238);
  Newborn admitted and discharged with same date (CPT code 99435).

- **Inpatient visits** (other than initial evaluation or discharge)
  (CPT codes 99218-99223).

☞ **Note: Circumcisions** (CPT code 54150 and 54160) only with medical diagnosis codes 605-Phimosis, 607.1-Balanoposthitis or 607.81-Balanitis Xerotica.

Neonatal Intensive Care Unit (NICU) **(CPT codes 99295-99297)**

[Refer to WAC 388-531-0900]

NICU care includes management, monitoring, and treatment of the neonate including nutritional, metabolic, and hematologic maintenance; parent counseling; and personal direct supervision by the health care team of cognitive and procedural activities.

NICU procedure codes are also included as part of the global descriptors (refer to your CPT manual).

MAA will reimburse for:

- One NICU service per client, per day.

- NICU (CPT codes 99295-99297) when directing the care of a neonate or infant in a NICU. These codes represent care beginning with the date of admission to the NICU.

  Note: Once the infant is no longer considered critically ill, hospital care CPT codes 99231-99233 must be used.

- NICU procedure codes in addition to prolonged services (CPT codes 99354, 99356) and newborn resuscitation (CPT code 99440) **when the physician is present at the delivery.**

The following are the services (with their corresponding CPT codes) that are included in reporting neonatal critical care. Do not bill these separately:

- The interpretation of cardiac output measurements (93561-93562)
- Chest x-rays (71010, 71015, and 71020)
- Blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data) (99090)
- Gastric intubation (43752 and 91105)
- Temporary transcutaneous pacing (92953)
- Ventilator management (94656-94657, and 94660-94662)
- Vascular access procedures (36000, 36410, and 36600)
- Blood draw for specimen (36415 and 36540)
- Pulse oximetry (94760-94762)
- Umbilical venous (36510)
- Umbilial arterial (36620) catheters
- Central (36488 and 36490) or peripheral vessel catheterization (36000)
- Other arterial catheters (36140 and 36620)
- Oral or nasogastric tube placement
- Endotracheal intubation (31500)
- Lumbar puncture (62270)
- Suprapubic bladder aspiration (51000)
- Bladder catheterization (53670)
- Initiation and management of mechanical ventilation (94656 and 94657)
- Continuous positive airway pressure (CPAP) (94660)
- Surfactant administration, intravascular fluid administration, transfusion of blood components (36430 and 36440)
- Vascular punctures (36420 and 36600)
- Invasive or noninvasive electronic monitoring of vital signs, bedside pulmonary function testing, and/or monitoring or interpretation of blood gases or oxygen saturation (94760-94762)

Physician Care Plan Oversight **(CPT codes 99375, 99378, and 99380)**

[Refer to WAC 388-531-1150]

MAA reimburses:

- Physician care plan oversight services once per client, per month.

  ✓ A plan of care must be established by the home health agency, hospice, or nursing facility;
  ✓ The physician must provide 30 or more minutes each calendar month of oversight to the client;

  Note: For physician care plan oversight in a home health agency, hospice and nursing facility, use CPT codes 99375, 99378, and 99380.

MAA does not reimburse:

- Bundled CPT codes 99374, 99377, and 99379.
- For more than one physician during the global surgery reimbursement period unless the care plan oversight is unrelated to the surgery.

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Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

What is the purpose of the EPSDT program?

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a federal preventive health care benefit. The purpose of this program is to screen clients **20 years of age and younger** in order to identify physical and/or mental defects. If a physical or mental defect is identified, the client should be treated or referred to an appropriate provider for treatment. EPSDT is designed to encourage continuing access to health care.

Access to and services for EPSDT are governed by federal rules at 42 CFR, Part 441, Subpart B.

MAA's standard for coverage is that the services, treatment, or other measures must be:

- Medically necessary;
- Safe and effective; and
- Not experimental.

Who can provide EPSDT screenings?

- Physicians;
- Advanced Registered Nurse Practitioners (ARNPs);
- Physician Assistants (PAs);
- Nurses specially trained through the Department of Health; and
- Registered nurses working under the guidance of a physician or ARNP may also do EPSDT screenings. However, only physicians, PAs and ARNPs can diagnose and treat problems found in a screening.

Who is eligible for EPSDT screenings?

MAA reimburses EPSDT screenings for clients who:

- Are 20 years of age and younger; and
- Present a DSHS Medical ID card with one of the following identifiers:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
CNP – Children's Health	CNP – Children's Health Program **Note: This program is scheduled to be discontinued with dates of service after 9/30/02.**
CNP – CHIP	CNP – Children's Health Insurance Program
CNP – Emergency Medical Only	CNP – Emergency Medical Only *(Covered only when the service is related to the emergent condition.)*
LCP-MNP	Limited Casualty Program – Medically Needy Program

☞ **Note:** Please refer clients to their local Community Services Office (CSO) if they are 20 years of age and younger and their DSHS Medical ID card does not list one of the above medical program identifiers. The CSO will evaluate these clients for a possible change in their Medical Assistance program that would enable them to receive EPSDT screenings.

Are clients enrolled in a Healthy Options managed care plan eligible for EPSDT?

Yes! EPSDT screenings are included in the scope of service under the Healthy Options managed care program. Clients who are enrolled in one of MAA's Healthy Options managed care plans will have an identifier in the HMO column on their DSHS Medical ID card.

Please refer Healthy Options managed care clients to their respective health care plan for necessary preventive health care services and medical treatments, including EPSDT services. Clients can contact their plan by calling the telephone number indicated on their DSHS Medical ID card.

Do not bill MAA for EPSDT services as they are included in the Healthy Options managed health care plan's reimbursement rate.

Primary Care Case Manger/Management (PCCM):

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain or be referred for services via the PCCM. The PCCM is responsible for coordination of care just like the PCP would be in a plan setting. Please refer to the client's DSHS Medical ID card for the PCCM.

> ☞ **Note:** To prevent billing denials, please check the client's DSHS Medical ID card prior to scheduling services and at the time of the service to make sure proper authorization or referral is obtained from the PCCM.

What are EPSDT screenings?

EPSDT screenings are defined by federal rules as "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development and nutritional status of infants, children and youth" that are provided as part of a health supervision program.

What is included in an EPSDT screening?

As a minimum, EPSDT screenings must include, but are not limited to:

- A comprehensive health and developmental history, updated at each screening examination;
- A comprehensive, **unclothed** physical examination performed at each screening examination;
- Appropriate vision testing;
- Appropriate hearing testing;
- Developmental assessment;
- Nutritional assessment;
- Appropriate laboratory tests;
- Dental/oral health assessment; including:
  - ✓ How to clean teeth as they erupt.
  - ✓ How to prevent baby bottle tooth decay.
  - ✓ How to look for dental disease.
  - ✓ Information on how dental disease is contracted.
  - ✓ Preventive sealant.
  - ✓ Application of fluoride varnish, when appropriate.
- Health education and counseling; and
- Age appropriate mental health and substance abuse screening.

These components may be performed separately by licensed providers; however, MAA encourages the primary care provider to perform as many of the components as possible to provide a comprehensive picture of the client's health.

Additional Screening Components:

The following screening component services may be billed in addition to the screening codes for fee-for-service clients by using procedure codes published in these billing instructions.

- ✓ Appropriate audiometric tests (CPT codes 92552 and 92553);
- ✓ Appropriate laboratory tests, including testing for anemia;
- ✓ Appropriate testing for blood lead poisoning in children in high-risk environments (CPT codes 82135, 83655, 84202, and 84203).

How often should EPSDT screenings occur?

The following is Washington State's schedule for health screening visits:

1. Five total screenings during the first year of the child's life. Below is a recommended screening schedule for children from birth to one year of age.

   - 1st Screening: Birth to 6 weeks old
   - 2nd Screening: 2 to 3 months old
   - 3rd Screening: 4 to 5 months old
   - 4th Screening: 6 to 7 months old
   - 5th Screening: 9 to 11 months old

2. Three screening examinations are required between the ages of 1 and 2 years.
3. One screening examination is required per 12-month period for children ages 2 through 6.
4. One screening examination is required per 24-month period for children age 7 through 20, except foster care clients, who receive a screening examination every 12 months.

Foster Care Children (As published in Numbered Memorandum 01-64 MAA)

Effective for claims with dates of service on and after November 1, 2001, through June 30, 2003, MAA will reimburse providers an enhanced flat fee of $120.00 per EPSDT screen for foster care children who receive their medical services through MAA's fee-for-service system. This applies to CPT™ codes 99381-99385 and 99391-99395 only.

To receive the enhanced rated, providers **must** include modifier 21 in field 24D on the HCFA-1500 claim form to identify the child as a foster care child.

Foster care is defined as:
Twenty-four hour per day temporary substitute care for a child placed away from the child's parents or guardians in licensed, paid, out-of-home care and for whom the department [DSHS] or a licensed or certified child placing agency has placement and care responsibility…

To receive the enhanced rate, providers are required to use either:

- The new DSHS "Well Child Exam" forms for Infancy, Early Childhood, Late Childhood, and Adolescence [DSHS 13-683 A-E(x), 13-684 A-C(x), 13-685 A-C(x), and 13-686A-B(x)]; **or**
- Another charting tool with equivalent information.

The Well Child Exam forms are available from the DSHS Warehouse at no cost and may be used for all children. After completion, these forms must be retained in the client's file.

To request copies of the Well Child Exam forms, write or fax:

DSHS Warehouse
PO Box 45816
Olympia, WA 98504-5816
FAX: (360) 664-0597
Or Download from the Internet:
http://www.wa.gov/dshs/dshsforms/forms/eforms.html

What are the time limits for scheduling requests for EPSDT screenings?

Requests for EPSDT screenings must be scheduled within the following time limits:

If an EPSDT screening is requested through…	For client who are…	Must be scheduled within…
Managed Care plans or Primary Care Providers (PCPs)	Infants – within the first 2 years of life.	Within 21 days of request.
	Children – two years and older.	Within six weeks of request.
Community Mental Health Center, Head Start, substance abuse provider, or Early Childhood Education and Assistance Program (ECEAP)	0 through 20 years of age	Within 14 days of the request.
Providers must ensure that when medically necessary services are identified during any EPSDT screening examination, appropriate treatment or referrals are made.		

What are EPSDT interperiodic screenings? (state-unique procedure code 0252M)

An EPSDT interperiodic screening (or "*interim screening*") is a modified or limited screening performed when a health problem is suspected, but the client has already received the maximum number of screening(s) for the year.

Physicians and ARNPs can bill, using a separate HCFA-1500 claim form, an evaluation and management procedure code (CPT codes 99201-99215) for clients (excluding managed care clients) who are found to have a medical problem. Use the ICD-9-CM diagnosis code that most accurately describes the client's condition. If no medical problem is found, bill MAA using state-unique procedure code 0252M.

For clients not enrolled in a managed care plan, when an immunization(s) is the only EPSDT service performed, an interperiodic screening may be billed in addition to the immunization.

What if a medical problem is identified during a screening examination?

If a medical problem is identified during a screening examination, the provider may:

- Provider the service for the client (if it is within the provider's scope of practice); or
- Refer the client to an appropriate provider for medical treatment.

Referrals

Chiropractic Services
Eligible clients may receive chiropractic services when a medical need for the services is identified through an EPSDT screening. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary chiropractic services.

Dental Services
Eligible clients may go to a dental provider without an EPSDT screen or referral. You should inform the client or the client's parent(s) or guardian(s) of the importance of oral/dental health and recommend that the client be seen by a dentist yearly, or sooner if a problem is suspected.

Note: Unless a problem is suspected earlier, the child should be at least 1 year of age and have his/her first tooth.

Orthodontics
Eligible clients may go to an orthodontic provider without an EPSDT screen or referral. MAA reimburses orthodontics for children with cleft lip or palates or severe handicapping maloclussions only. You must obtain prior authorization from MAA before providing orthodontic services. MAA does not reimburse orthodontic treatment for other conditions.

Lead Toxicity Screening
Providers are no longer required to use the Lead Toxicity Screening Risk Factor questionnaire. Health care providers should use clinical judgment when screening for lead toxicity.

Fetal Alcohol Syndrome (FAS) Screening
FAS is a permanent birth defect syndrome caused by the mother's consumption of alcohol during pregnancy. FAS is characterized by cognitive/behavioral dysfunction caused by structural and/or chemical alterations of the brain, a unique cluster of minor facial anomalies, and if often accompanied by growth deficiency.

As part of the EPSDT screen every child six months of age and older should be screened for risk of exposure to material consumption of alcohol and for the facial characteristics of FAS. Children for whom there is known in utero exposure and for whom there is suspicion of facial characteristics of FAS and/or microcephaly can be referred to a diagnostic clinic.

Medical Nutrition Therapy

If an EPSDT screening provider suspects or establishes a medical need for medical nutrition therapy, eligible clients may be referred to a certified dietitian to receive outpatient medical nutrition therapy. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary medical nutrition therapy.

MAA covers the procedure codes listed below when referred by an EPSDT provider.

☞ **Note:** Medical nutrition therapy is a face-to-face interaction between the certified dietitian and a client and/or caregiver. MAA limits initial assessments to 2 hours (or 8 units) per year and reassessments to no more than 1 hour (or 4 units) per day. MAA limits group therapy to 1 hour (or 4 units) per day. MAA reimburses for medical nutrition therapy only when referred by an EPSDT provider.

Last year, MAA assigned flat fees to the medical nutrition therapy procedures, as there were no Medicare-assigned RVUs. However, Medicare has since assigned RVUs to these procedures. Effective 7/1/02, MAA will adopt these RVUs and establish fees using the RBRVS methodology. Due to the change in the fee-setting methodology, MAA will also revise the unit description and unit limitations for group therapy as described below:

Due to its licensing agreement with the American Medical Association, MAA publishes only the official, brief CPT code descriptions. To view the full descriptions, please refer to your current CPT book.

CPT Procedure Code	Brief Description
97802	Medical nutrition, indiv, initial [1 unit = 15 minutes; maximum of 2 hours (8 units) per year]
97803	Med nutrition, indiv, subseq [1 unit = 15 minutes; maximum of 1 hour (4 units) per day]
97804	Medical nutrition, group [1 unit = 15 minutes; maximum of 1 hour (4 units) per day]

Provider must document beginning and ending times in the client's medical record.

Fluoride Varnish (Physicians and ARNPs)

(State-unique code 0122D)

In cooperation with the University of Washington's School of Dentistry, the Medical Assistance Administration's (MAA) goal is to improve the oral health of Medicaid-eligible clients, 18 years of age and younger, through the application of fluoride varnish.

In order to achieve this goal effectively, a protocol has been developed for physicians, advanced registered nurse practitioners, and nurses to apply fluoride varnish to the teeth of Medicaid-eligible children.

What is fluoride varnish? How often is it applied?

Fluoride varnish is a type of topical fluoride that acts to retard, arrest and reverse the caries process. It is applied up to three times per year to all surfaces of the teeth. The teeth then absorb the fluoride varnish, strengthening the enamel and helping prevent cavities.

These fluoride varnish applications are viewed as preventive in nature and are not intended to replace routine dental care by a dentist.

Who must order the fluoride varnish?

- Dentists;
- Physicians; or
- Advanced Registered Nurse Practitioners (ARNP).

Who is eligible?

All Medicaid-eligible clients, 18 years of age and younger, may receive fluoride varnish applications. DDD clients age 19 and older are also eligible.

Are managed care clients eligible?

Clients whose DSHS Medical ID cards have an identifier in the HMO column are enrolled in a Healthy Options managed health care plan. These clients **are eligible for fluoride varnish applications** through fee-for-service. Fluoride varnish applications must be billed directly to MAA for reimbursement.

Immunizations – Children

(This applies to clients 20 years of age and younger. For clients 21 years of age and older, refer to the Immunizations-Adults on page C12.

The following procedure codes must be used to bill for the administration of immunizations:

Procedure Code	Brief Description	7/1/02 Maximum Allowable Fee Non-Facility Setting	Facility Setting
90471	Immunization admin	$5.00	$5.00
90472	Immunization admin, each add	$3.00	$3.00

Immunizations for EPSDT are usually given in conjunction with a screening or interperiodic screening. Do not bill an Evaluation and Management (E&M) code unless there is a separate, identifiable diagnosis that is different from the immunization.

- MAA will reimburse an administration fee (up to $5.00) for vaccines available through the state's Universal Vaccine Distribution program and the Federal Vaccines for Children program for children 18 years of age and under. When immunization materials are received from the Department of Health, you must bill the appropriate procedure code with **modifier –SL** (e.g., 90700-SL). **In the following list, the procedure codes that are shaded identify these vaccines. Do not bill CPT codes 90471 and 90472.**

- Do not bill with modifier -SL for any of the procedure codes listed on the following page if the client is 19 through 20 years of age, or if the procedure code is NOT shaded.

- Bill 90471 and 90472 with the vaccine or toxoid procedure code.

- Do not bill administration codes 90471 and 90472:

  ✓ As multiple units; or
  ✓ More than once per client, per day.

- Bill only CPT code 90471 when administering one vaccine. Bill both CPT codes 90471 and 90472 with one unit per code when administering more than one vaccine. MAA will reimburse a maximum of $8.00 when:

  ✓ More than one vaccine is administered; and,
  ✓ Both CPT codes 90471 and 90472 are billed; and,
  ✓ Those vaccines are not available through the state's Universal Vaccine Distribution program or Federal Vaccines for Children program.

- When an immunization is the only service performed, an interperiodic screen (0252M) may be billed.

- Reimbursement rates for immunization materials include federal excise tax.

- For all providers **except Health Departments**, MAA adopts CPT guidelines regarding billing E&M procedures with immunizations. The only time that an E&M procedure can be billed with an immunization is if there is a separate, identifiable diagnosis. If a Health Department gives the immunization and it is the only service performed, continue to bill E&M CPT code 99211.

See immunization list on following page.

Due to its licensing agreement with the American Medical Association, MAA publishes only the official, brief CPT code descriptions. To view the full descriptions, please refer to your current CPT book.

CPT	Immunization	CPT	Immunization
90585	Bcg vaccine, percut	90735	Encephalitis, vaccine, sc
90586	Bcg vaccine, intravescial	90740	Hepb vacc, ill pat 3 dose im
90632	Hep a vaccine, adult im	90743	Hep b vacc, adol, 2 dose, im
90633	Hep a vacc, ped/adol, 2 dose	90744	Hepb vacc ped/adol 3 dose, im
90645	Hib vaccine, hboc, im	90746	Hep b vaccine, adult, im
90646	Hib vaccine, prp-d, im	90747	Hepb vacc, ill pat 4 dose, im
90647	Hib vaccine, prp-omp, im	90748	Hep b/hib vaccine, im
90648	Hib vaccine, prp-t, im	90749	Vaccine toxoid
90657	Flu vaccine, 6-35 mo, im		
90658	Flu vaccine, 3 yrs, im		
90659	Flu vaccine, whole, im		
90665	Lyme disease vaccine, im		
90669	Pneumococcal vacc, ped<5		
90675	Rabies vaccine, im		
90676	Rabies vaccine, id		
90690	Typhoid vaccine, oral		
90691	Typhoid vaccine, im		
90692	Typhoid vaccine, h-p, sc/id		
90700	Dtap vaccine, im		
90701	Dtp vaccine, im		
90702	Dt vaccine <7, im		
90703	Tetanus vaccine, im		
90704	Mumps vaccine, sc		
90705	Measles vaccine, sc		
90706	Rubella vaccine, sc		
90707	Mmr vaccine, sc		
90708	Measles-rubella vaccine, sc		
90709	Rubella & mumpsvaccine, sc		
90712	Oral poliovirus vaccine		
90713	Poliovirus, ipv, sc		
90716	Chicken pox vaccine, sc		
90717	Yellow fever vaccine, sc		
90718	Td vaccine >7, im		
90720	Dtp/hib vaccine, im		
90725	Cholera vaccine, injectable		
90732	Pneumococcal vacc, adult/ill		
90733	Meningococcal vaccine, sc		

Immunizations-Adults

(This section applies to clients 21 years of age and older. For clients 20 years of age and younger, refer to the Immunizations-Children Section, page C9.

Immunization materials are reimbursed at MAA's established Maximum Allowable Fee (MAF). Bill administration CPT codes 90471 and 90472 in addition to the immunization materials.

Do not bill an E&M procedure with an administration unless there is a separate identifiable diagnosis from the administration.

- Do not bill administration codes 90471 and 90472:
  - ✓ As multiple units; or
  - ✓ More than once per client, per day.

- Bill only CPT code 90471 when administering one vaccine. Bill both CPT codes 90471 and 90472 with one unit per code when administering more than one vaccine. MAA will reimburse a maximum of $8.00 when:
  - ✓ More than one vaccine is administered; and,
  - ✓ Both CPT codes 90471 and 90472 are billed.

- Reimbursement rates for immunization materials include federal excise tax.

CPT	Immunization	CPT	Immunization
90585	Bcg vaccine, percut	90705	Measles, vaccine, sc
90586	Bcg vaccine, intravesical	90706	Rubella vaccine, sc
90632	Hep a vaccine, adult im	90707	Mmr vaccine, sc
90636	Hep a/hep b vacc, adult im	90708	Measles-rubella vaccine, sc
90645	Hib vaccine, hboc, im	90709	Rubella & mumps vaccine, sc
90646	Hib vaccine, prp-d, im	90712	Oral poliovirus vaccine
90647	Hib vaccine, prp-omp, im	90713	Poliovirus, ipv, sc
90648	Hib vaccine, prp-t, im	90716	Chicken pox vaccine, sc
90658	Flu vaccine, 3 yrs, im	90717	Yellow fever vaccine, sc
90659	Flu vaccine, whole, im	90718	Td vaccine >7, im
90665	Lyme disease vaccine, im	90720	Dtp/hib vaccine, im
90675	Rabies vaccine, im	90725	Cholera vaccine, injectable
90676	Rabies vaccine, id	90732	Pneumococcal vacc, adult/ill
90690	Typhoid vaccine, oral	90733	Meningococcal vaccine, sc
90691	Typhoid vaccine, im	90735	Encephalitis vaccine, sc
90692	Typhoid vaccine, h-p, sc/id	90740	Hepb vacc, ill pat 3 dose, im
90700	Dtap vaccines, im	90746	Hep b vaccine, adult, im
90701	Dtp vaccine, im	90747	Hepb vacc, ill pat 4 dose, im
90703	Teanus vaccine, im	90748	Hep b/hib vaccine, im
90704	Mumps vaccine, sc	90749	Vaccine toxoid

Immune Globulins

- **RespiGam** – Bill HCPCS code J1565 for Respigam only.

- **Synagis (CPT code 90378)** – MAA covers this immune globulin only after prior authorization has been obtained. The following payment levels have been established for Synagis:

Number of Units	Description	Maximum Allowable Fee
1	Synagis, 50 mg	$598.00
2	Synagis, 100 mg	$1,128.00
3	Synagis, 150 mg	$1,726.00
4	Synagis, 200 mg	$2,256.00

✓ Bill one unit for each 50 mg of Synagis used.
✓ MAA reimburses for Synagis at the lesser of billed charges or MAA's maximum allowable fee regardless of place of service.

Requests for authorization must be submitted in writing to:

MAA-Division of Medical Management
Attn: Synagis Program
PO Box 45506
Olympia, WA 98504-5506
FAX: (360) 586-1471

- **Hepatitis B** (CPT code 90371) – Reimbursement is based on the number of 1 ml syringes used. Bill each 1 ml syringe used as 1 unit.

- **Immune Globulins** - CPT codes 90287, 90288, 90296 and 90393 are not covered if the provider obtained the immune globulins at no cost from either the Center for Disease Control or California Department of Health. MAA reimburses the provider for the administration of the immune globulin using CPT codes 90782-90784.

For CPT code 90396 (varicella-zoster immune globulin), each one unit billed equals one 125-unit vial, with a maximum reimbursement of five vials per session.

CPT codes 90281, 90283, 90291, 90379, 90384, 90385, 90386, and 90389 are not covered. Use the appropriate J codes listed in the following table:

Non-Covered CPT Code	Covered HCPCS Code
90281	J1460-J1560
90283	J1561, J1563
90291	J0850
90379	J1565
90384	J2790
90385	J2790
90386	J2792
90389	J1670

- ## Rabies Immune Globulin (RIG) (CPT codes 90375-90376)

✓ RIG is reimbursed at acquisition cost.

✓ RIG is given based on .06 ml per pound of body weight. The dose is rounded to the nearest tenth of a milliliter (ml). Below are the recommended dosages up to 300 pounds of body weight:

Pounds	Dose
0-17	1 ml
18-34	2 ml
35-50	3 ml
51-67	4 ml
68-84	5 ml
85-100	6 ml
101-117	7 ml
118-134	8 ml
135-150	9 ml

Pounds	Dose
151-167	10 ml
168-184	11 ml
185-200	12 ml
201-217	13 ml
218-234	14 ml
235-250	15 ml
251-267	16 ml
268-284	17 ml
285-300	18 ml

✓ RIG is sold in either 2 ml or 10 ml vials.
✓ One dose is allowed per episode.
✓ Bill one unit for each 2 ml vial used per episode.

For example:
- ➢ If a patient weighs 83 pounds, three 2 ml vials would be used. The number of units billed would be three; or
- ➢ If a patient weighs 240 pounds, both one 10 ml vial and three 2 ml vials or eight 2 ml vials could be used. The number of units billed would be eight.

Therapeutic or Diagnostic Injections
(CPT codes 90782-90784, 90788, 90799)

[Refer to WAC 388-531-0950]

- MAA reimburses physicians for injection procedures and/or injectable drug products provided to a client only when the injectable drug used is from office stock purchased by the physician from a pharmacist or drug manufacturer.

- If no other service is performed on the same day, a subcutaneous or intra-muscular injection (CPT code 90782) or an intra-muscular antibiotic injection (CPT code 90788) can be billed in addition to an injectable drug code.

- When a subcutaneous or intra-muscular injection (CPT code 90782) or an intra-muscular antibiotic injection (CPT code 90788) is provided on the same day as and Evaluation & Management (E&M) service, the injections are bundled into the E&M service and are not reimbursed separately.

- Intra-arterial injections (CPT code 90783) and intravenous therapeutic or diagnostic injections (CPT code 90784) are reimbursed separately even when provided on the same day as an E&M service. Separate payment for the drug is allowed. Use the appropriate HCPCS injection drug code. These injections are <u>not</u> reimbursed separately if provided in conjunction with IV infusion therapy services (CPT codes 90780 and 90781).

> ☞ **Note:** Drugs must be billed using the HCPCS drug codes and are reimbursed at MAA's established maximum allowable fees. Name, strength, and dosage of the drug must be documented and retained in the client's file for review. For billing and reimbursement of chemotherapy services, see page F7.

Hyalgan/Synvisc

- Only orthopedic surgeons and rheumatologists are reimbursed for Hyalgan or Synvisc.
- MAA allows a maximum of 5 Hyalgan or 3 Synvisc intra-articular injections **per knee** for the treatment of pain in osteoarthritis of the knee. Identify left knee or right knee by adding the appropriate "LT" or "RT" modifier to your claim.
- MAA changed the pricing of Hyalgan (HCPCS code J7316) and Synvisc (HCPCS code J7320) to match the dosage within the description of the code.

HCPCS Code	Description	Restrictions
J7316	Sodium hyaluronate, 5 mg, for intra-articular injection (Hyalgan) [1 unit = 5 mg]	Maximum of 5 injections Maximum of 20 units (4 units = 1 injection)
J7320	Hylan G-F 20, 16 mg, for intra-articular injection (Synvisc) [1 unit = 16 mg]	Maximum of 3 injections Maximum of 3 units (1 unit = 1 injection)

- Hyalgan and Synvisc injections are covered for treatment of osteoarthritis of the knee only with the following diagnoses:

Diagnosis Code	Description
715.16	Osteoarthritis, localized, primary lower leg.
715.18	Osteoarthritis, localized, primary, other specified sites.
715.26	Osteoarthritis, localized, secondary, lower leg.
715.28	Osteoarthritis, localized, secondary, other specified sites
715.36	Osteoarthritis, localized, not specified whether primary or secondary, lower leg.
715.38	Osteoarthritis, localized, not specified whether primary or secondary, other specified sites.
715.96	Osteoarthritis, unspecified whether generalized or localized, lower leg.
715.98	Osteoarthritis, unspecified whether generalized or localized, other specified sites.

- The series of injections must be billed after all injections are completed. It is billed as five (5) units for Hyalgan and three (3) units for Synvisc (per knee).
- Bill CPT injection code 20610 each time an injection is given, up to a maximum of 5 injections for Hyalgan and 3 injections for Synvisc.
- **You must bill both the injection CPT code and HCPCS drug codes on the same claim form.**

Clozaril Case Coordination

- Only physicians, psychiatrists, ARNPs, and pharmacists are reimbursed.
- One Clozaril case coordination, state unique code 0857J, is allowed per week.
- Routine venipuncture (CPT code 36415) and a blood count (CBC) (CPT code 85022) may be billed in combination when providing Clozaril case coordination.

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Vision Care Services (Includes Ophthalmological Services)

Who is eligible for vision care services?

Clients with one of the following identifiers on their DSHS Medical ID cards are eligible for vision care services:

Medical Program Identifier	Medical Program
CNP	Categorically Needy Program
CNP – CHIP	Categorically Needy Program – Children's Health Insurance Program
CNP – Children's Health	Categorically Needy Program – Children's Health
CNP – Emergency Medical Only	Categorically Needy Program – Emergency Medical Only *(Covered only when the service is related to the emergent condition.)*
GA-U – No Out of State Care	General Assistance-Unemployable – No Out of State Care
General Assistance	ADATSA
LCP-MNP	Limited Casualty Program – Medically Needy Program
LCP-MNP Emergency Medical Only	Limited Casualty Program – Medically Needy Program *(Covered only when the service is related to the emergent condition)*
Note: Clients with **Family Planning Only** and **TAKE CHARGE** identifiers are NOT covered.	

Limited Coverage:

Office and ambulatory surgical center services are not payable when the client(s) has the following identifier on their DSHS Medical ID cards. In certain situations, a client is put on the Medically Indigent Program (MIP) for the sole purpose of cataract surgery or retinal detachment.

Medical Program Identifier	Medical Program
Emergency Hospital and Ambulance Only	Medically Indigent Program

For clients with the following identifier on their DSHS Medical ID card, MAA only pays the Medicare premiums and copay.

Medical Program Identifier	Medical Program
QMB-Medicare Only	Qualified Medicare Beneficiary **(Medicare Premiums/Copays Only)**

Are clients enrolled in a Healthy Options managed care plan eligible for vision care services?

Clients with an identifier in the HMO column on their DSHS Medical ID card are enrolled in one of MAA's managed care plans. **Eye exams, refractions, and/or visual fields** must be requested and provided directly through the client's Healthy Options managed care plan. Clients can contact their plans by calling the telephone number listed on their DSHS Medical ID card .

Frames, lenses, and contact lenses must be ordered from MAA's contractor (see page D16). These items are reimbursed fee-for-service. Eligibility, coverage, and billing guidelines found in this billing instruction and MAA's Vision Care Services Billing Instruction apply to Healthy Options clients.

Primary Care Case Management (PCCM) clients will have the PCCM identifier in the HMO column on their DSHS Medical ID cards. Please make sure these clients have been referred by their PCCM prior to receiving services. The referral number is required in field 17A on the HCFA-1500 claim form.

> ☞ **Note: For further information on Healthy Options, see MAA's Web site: http://maa.dshs.wa.gov/HealthyOptions.**

What services are covered and how often?

Eye examinations, refractions, and fitting fees

MAA covers medically necessary eye examinations, refractions, eyeglasses (frames and lenses), and fitting fees as follows:		
Asymptomatic clients	Adults (21 year or older)	Once every 24 months
Asymptomatic clients	Children (20 years or younger)	Once every 12 months
Clients identified by MAA as developmentally disabled ***(DSHS Medical ID card will have an "X" in the DD Client column.)***	Adults and Children	Once every 12 months

(The provider must document the diagnosis and/or treatment in the client's record to justify the frequency of examinations and other services.) MAA limits eyeglass reimbursement to specific contract frames and contract lenses. MAA pays a fitting fee for frames, lenses, and contact lenses provided by, or obtained through, the contractor (see page D16). If the client has serviceable frame that meets MAA's size and style requirements, MAA will pay for a fitting fee.

Under what circumstances would the above previous limits NOT apply?

1. **Change in prescription (spherical equivalent of ±1 diopter):** The 24-month limitation does not apply to a change in prescription spherical equivalent of ±1 diopter. To justify this diopter change, you must use **state-unique diagnosis code 367.99**.

2. **Clients in nursing facilities:** MAA reimburses for services provided to clients in a nursing facility. Services must be ordered by the client's attending physician and documented in the facility's client care plan. The need for services must be clearly documents in the facility's client medical record, and the corresponding services provided must be documented in the medical record at the time the services are delivered.

3. **Eye examinations relating to medical conditions:** MAA reimburses for examinations relating to medical conditions (e.g., glaucoma, conjunctivitis, corneal abrasion/laceration, etc.) as often as medically necessary.

4. **Eye exam due to lost or broken glasses**

   MAA covers eye exams within two years of the last exam when no medical indication exists and **both** of the following are documented in the client's record:

   - The glasses or contacts are broken or lost; and
   - The last exam was 18 months ago or longer.

   Note: Use MAA's Expedited Prior Authorization. See Section I – Authorization.

5. **Visual field exams (CPT codes 92081, 92082, and 92083)** MAA covers visual field exams for the diagnosis and treatment of abnormal signs, symptoms, or injuries. MAA does not reimburse visual field exams that are done by simple confrontation. Use Medicare criteria for the billing of visual field services for MAA clients. Your records must support medical necessity for the visual field tests.

   Documentation in the record must show:

   ✓ The extent of the testing;
   ✓ White the testing was reasonable and necessary for the client; and
   ✓ The medical basis for the frequency of testing.

Program Limitations

Special Ophthalmological Services – Bilateral Indicator: MAA considers special ophthalmological services to be bilateral if they are routinely provided on both eyes. For MAA purposes, this includes CPT code 92015, determination of refractive state. Do not use bilateral modifier 50 or modifiers LT and RT for these services since payment is based on a bilateral procedure.

Reporting Diagnoses: MAA requires a diagnosis for a medical condition. The diagnosis assigned to a procedure is the first-level justification for that procedure. Please note: Use V72.0 (Examination of eyes and vision) only for eye exams in which no problems were found.

E&M Procedures: Use Evaluation and Management (E&M) codes for eye examinations for a medical problem, not for the prescription of eyeglasses or contact lenses. ICD-9-CM diagnosis codes 367.0-367.9 and "V" codes are not appropriate when billing E&M services.

What services are not covered?

MAA does not cover:

- ✓ Evaluation and Management (E&M) codes and an eye exam on the same day;
- ✓ Nursing home visits and an eye exam on the same day;
- ✓ Any services with prescriptions over two years old;
- ✓ Missed appointments;
- ✓ Orthoptics and visual training therapy; or
- ✓ Group vision screening for eyeglasses (except for EPSDT services).

Eyeglasses

When does MAA cover eyeglasses (frames and/or lenses)?

MAA coveres eyeglasses (frames and/or lenses) when the:

- Client's condition that requires correction in one or both eyes is stable;
- Prescription is less than two years old; and
- Minimum correction need is documented and meets one of the following:
  - ✓ Sphere power equal to, or greater than, plus or minus 0.50 diopters; or
  - ✓ Astigmatism power equal to, or greater than, plus or minus 0.50 diopters.

MAA limits eyeglass reimbursement to specific contract frames, lenses, and contact lenses. MAA pays a fitting fee for **only** frames, lenses, and contact lenses provided by, or obtained through MAA's contractor (see page D16). However, if the client owns serviceable frames that meet MAA's size and style requirements, MAA pays for a fitting fee.

Requests for lenses only

MAA covers requests for lenses only when:

- The eyeglass frames are serviceable,* and
- The size and style of the required len(s) and/or frame type meets MAA requirements.

***Note:** Due to time, exposure to elements, and concealed damage working with these frames can be unpredictable. MAA's contractor does not accept responsibility for these frames.

How often does MAA cover eyeglasses (lenses/frames)?

MAA covers eyeglasses as follows:		
Clients	Adults (21 years or older)	Once every 24 months
Clients	Children (20 years or younger)	Once every 12 months
Clients identified by MAA as developmentally disabled ***(DSHS Medical ID card will have an "X" in the DD Client column.)***	Adults and Children	Once every 12 months
Clients who have been unable to adjust to contact lenses after 30 days	Adults and Children	As medically necessary *(The provider must document the client's inability to adjust and the client must return the eyeglasses to the provider.)*

Replacements

MAA covers replacement eyeglasses (lenses/frames) that have been broken or lost as follows:	
Clients 21 years and older	Requires MAA's expedited prior authorization (see Section I)
Clients 20 years and younger	Does not require MAA's prior authorization
Clients identified by MAA as developmentally disabled, regardless of age ***(DSHS Medical ID card will have an "X" in the DD Client column.)***	Does not require MAA's prior authorization

Additional Options

Nonallergenic frames

If the client has a medically diagnosed allergy to metal, MAA covers coating the frames to make them nonallergenic.

Upgrades

MAA **does not** authorized clients to upgrade eyeglass frames and pay only the upgrade costs in order to avoid MAA's contract limitations.

Back-up eyeglasses

MAA covers back-up eyeglasses when contact lenses are the client's primary visual correction aid (see Contact Lenses section, page D12) as follows:

Clients 20 years or younger	One pair every two years
Clients 21 years and older	One pair every six years

Durable or Flexible Frames

MAA covers pre-approved special frames called "durable frames and flexible frames" through MAA's contracted supplier when a client:

- Is diagnosed with a seizure disorder that results in frequent falls; or
- Has a medical history that has resulted in two or more broken eyeglass frames in a 12-month period.

☞ **Note: You must bill using MAA's Expedited Prior Authorization (EPA) process. See Section I.**

What is not covered?

MAA does **not cover** the following eyeglasses:

- ✓ Eyeglasses upgraded at private expense to avoid MAA's contractual limitations;
- ✓ Two pairs of glasses in lieu of multifocals; or
- ✓ Non-medically necessary glasses.

Eyeglass Lenses

What is covered?

MAA covers the following eyeglass lenses and lens treatments:

Eyeglass Lenses and Lens Treatment (through Contractor)

1. One pair of:

- Single vision;
- Round or flat top D-style bifocals; and
- Trifocals (25 mm or 28 mm);

2. Glass Lenses (in clear only)

In eye-size 54 millimeters or smaller for all contract frames or noncontract serviceable* frames owned by MAA clients.

***Note:**	Due to time, exposure to elements, and concealed damage, working with noncontract frames owned by MAA clients can be unpredictable. MAA's contractor does not accept responsibility for these frames.

3. Plastic Lenses (in clear only)

In all sizes to fit all contract frames or noncontract frames owned by MAA clients. Plastic lenses can be up to any prescription power. (For information on tinted lenses, see page D9.)

4. Treating Plastic Lenses for Scratch Resistance

MAA covers treating plastic lenses for scratch resistance only when the client:

- Is 20 years of age or younger; or
- Is determined by MAA to be developmentally disabled (check the client's DSHS Medical ID card for an "X" in the DD column.

Requests for lenses only

MAA covers requests for lenses only when:

- The eyeglass frames are serviceable,* and
- The size and style of the required lense(s) and/or frame type meets MAA requirements.

***Note:** Due to time, exposure to elements, and concealed damage, working with noncontract frames owned by MAA clients can be unpredictable. MAA's contractor does not accept responsibility for these frames.

Which eyeglass lenses and lens treatment require medical justification?

Medical justification and/or ICD-9-CM diagnosis code(s) must be clearly written on the order form to the contract for the following lenses:

1. Bifocal Lenses Replaced with Single Vision Lenses – or –
Trifocal Lenses Replaced with Bifocal Lenses or Single Vision Lenses

Due to a client's normal inability to adjust quickly to lens changes, MAA requires **all of the following** before allowing lenses to be replaced as specified above:

- A client must attempt to adjust to the bifocals or trifocals for at least 60 days;
- The client is unable to make the adjustments; and
- The bifocal or trifocal lenses are returned to the provider.

A statement from the attending physician must be in the client's record indicating that the treatable condition(s) is stable before new lenses may be allowed.

2. High Index Lenses for Refractive Change

MAA covers high index lenses when the client requires a refractive corrections of plus or minus 8 diopters or greater.

☞ **Note: You must bill using MAA's Expedited Prior Authorization (EPA) process. See Section I.**

3. Executive Bifocals or Trifocals (plastic only)

MAA covers plastic executive bifocals or trifocals only for clients who are diagnosed with:

- Accommodative estropia (client demonstrates that one or both eyes tend to turn in under fatigue or stress); or
- Strabismus.

☞ **Note: You must bill using MAA's Expedited Prior Authorization (EPA) process along with ICD-9-CM diagnosis codes 378.0-378.9. See Section I.**

4. Tinting of Plastic Lenses

MAA covers the tinting of plastic lenses only when:

- The client's medical need is diagnosed and documented as a chronic eye condition (expected to last longer than 3 months) causing photophobia; and
- The tinting is done by MAA's contracted lens supplier.

When billing MAA, use the appropriate ICD-9-CM code from the following list:

Medical Problems	ICD-9-CM Diagnosis Codes
Chronic iritis, iridocyclitis (uveitis)	364.10-364.11 364.51-364.59
Optic atrophy and/or optic neuritis Causing photophobia	377.10-377.63
Chronic corneal keratitis	370.00-370.07
Glaucoma	365.00-365.9
Rare photo-induced epilepsy conditions	345.00-345.91
Migraine disorder	346.00-346.21
Diabetic retinopathy	362.01-362.02

5. Glass Photochromatic Lenses (includes photogray lenses)
Plastic photochromatic lenses are not allowed.

MAA covers glass photochromatic lenses only when the client's medical need is diagnosed and documents as related to either of the following:

- Ocular albinism; or
- Blindness.

Medical Problems	ICD-9-CM Diagnosis Codes
Albinism	270.2
Retinitis pigmentosa	362.74
Optic atrophy and/or optic neuritis	377.10-377.63

6. Polycarbonate Lenses

MAA covers polycarbonate lenses when a client:

- Is blind in one eye (see definition for "blind") and needs protection for the other eye, regardless of whether a vision correction is required; or
- Is 20 years of age or younger and diagnosed with strabismus or amblyopia; or
- Is identified by MAA as developmentally disabled, regardless of the client's age.

Medical Problems	ICD-9-CM Diagnosis Codes	
Persons who are blind in one eye and need protection for the other eye.	369.60-369.69 369.71-369.73	
Infants/toddlers with motor ataxia	331.89 334.0-334.9	781.2 781.3
Amblyopia	368.01-368.03	
Young children with strabismus	378.00-378.9	

Replacements

- MAA covers lens replacement for lost, broken, or stolen lenses (outside the 90-day warranty period provided by the contractor) as follows:

Clients 21 year and older	**Requires MAA's EPA Process** (see Section G)
Clients 20 years and younger	Does not require MAA's prior authorization.
Clients identified by MAA as developmentally disabled, regardless of age ***(DSHS Medical ID card will have an "X" in the DD Client column.)***	Does not require MAA's prior authorization.

- MAA covers lens replacements through the expedited prior authorization (EPA) process without regard to time limits when all of the following apply:

  ✓ One of the following caused the vision change:

  - Eye surgery;
  - The effect(s) of prescribed medication; or
  - One or more diseases;

  ✓ Both the eye condition and the treatment have stabilized; and
  ✓ The lens correction has at least one diopter difference between the old and new prescriptions. (A change of at least one diopter does not apply to separate pairs of eyeglasses for distance and reading, or for two pair of eyeglasses in place of multifocals.)

What lenses are not covered?

MAA does **not cover** the following eyeglass lenses:

✓ High index lenses with correction less than 8 diopters;
✓ Second or replacement lenses during pregnancy due to unstable refractive changes;
✓ Plastic photochromatic lenses;
✓ Glass lenses of prescription power plus or minus 8 diopters
✓ Varilux or other progressive additon-type multifocals, including blended bifocals; or
✓ Sunglasses.

Contact Lenses

How often does MAA cover contact lenses?

MAA covers contact lens replacements only once every 12 months.

What is covered?

MAA covers the following contact lenses:

1. **Gas permeable or daily wear soft contact lenses** as the client's primary refractive correction method if a client has a vision correction of plus or minus 6.0 diopters. (Use ICD-9-CM codes 367.0 or 367.1.)

2. **Therapeutic contact bandage lenses** only when needed immediately after either of the following:

   - Eye injury (ICD-9-CM codes 871.0-871.9); or
   - Eye surgery (CPT codes 65091-67599, 68020-68399).

   ☞ **Note:** MAA does not cover contact lenses if the client's ocular condition makes it inadvisable for the client to use contact lenses.

3. **Lenticular, aspheric, and myodisc contact lenses** when the client has one ore more of the following:

   - Multiple cataract surgeries on the same eye;
   - Aphakia;
   - Keratoconus with refractive error of plus or minus 10 diopters; or
   - Corneal softening (e.g., bullous keratopathy).

Medical Problems	ICD-9-CM Diagnosis Codes
Aphakia	379.31 743.35
Keratoconus	371.60-371.62 743.41
Multiple cataract surgeries on the same eye (12-month limit does not apply)	366.00-366.09 366.17-366.9
Corneal softening, such as caused by Bullous Kerotopathy	371.23

4. **Soft toric contact lenses** (daily wear) for clients with astigmatism requiring a vision correction of plus or minus one diopter. They must also meet the vision requirement listed in #1. (Use ICD-9-CM codes 367.20, 367.21, or 367.22 for astigmatism.)

Replacements

MAA covers the replacement of contacts within one year of the last dispense when contacts are broken or lost and **both** of the following are documented in the client's record:

- Copy of current prescription (must not be older than 17 months); and
- Date of last dispense documented.

☞ **Note: You must bill using MAA's Expedited Prior Authorization (EPA) process. See Section I.**

What contact lenses are not covered?

✓ Contact lenses for a client who has received MAA-covered eyeglasses within the past 2 years, unless the provider can document the medical necessity to MAA's satisfaction;
✓ Disposable contact lenses; or
✓ Contact lenses upgraded at private expense to avoid MAA's contract limitations.

Billing for Fitting Fees

Please use the following state-unique procedure codes when billing MAA for fitting fees for contact lenses.

State-Unique Procedure Code	Description
9275M	Fitting fee including dispensing for therapeutic bandage lenses. (This includes 14-day follow-up care.)
9276M	Fitting fee including dispensing for contact lenses. (This includes 30-day follow-up care for the training period.)
9277M	Fitting fee including dispensing of contact lenses for treatment for disease. (This includes 90-day follow-up care.)

Ocular prosthetics

When does MAA cover ocular prosthetics?

MAA covers ocular prosthetics when they are medically necessary and provided by any of the following enrolled/contracted providers:

- An Ophthalmologist;
- An Ocularist; or
- An Optometrist who specializes in orthotics.

HCPCS Procedure Codes: Please use one of the following HCPCS procedure codes when billing for Ocular Prosthesis.

HPCS Code	Description
V2623	Prosthetic, eye, plastic, custom
V2624	Polishing/resurfacing of ocular prosthesis
V2625	Enlargement of ocular prosthesis
V2626	Reduction of ocular prosthesis
V2627	Scleral cover shell
V2628	Fabrication and fitting of ocular conformer
V2630	Anterior chamber intraocular lens
V2631	Iris, supported intraocular lens
V2632	Posterior chamber intraocular lens

Cataract Surgeries

When does MAA cover cataract surgery?

MAA covers cataract surgery when it is medically necessary and the provider clearly documents the need in the client's file.

MAA considers the surgery medically necessary when the client has either of the following:

- Correctable visual acuity in the affected eye at 20/50 or worse, as measured on the Snellen test chart; or
- One or more of the following conditions:

  ✓ Dislocated or subluxated lens;
  ✓ Intraocular foreign body;
  ✓ Ocular trauma;
  ✓ Phacogenic glaucoma;
  ✓ Phacogenis uveitis; or
  ✓ Phacoanaphylactic endopthalmitis.

Strabismus Surgeries

When does MAA cover strabismus surgery?

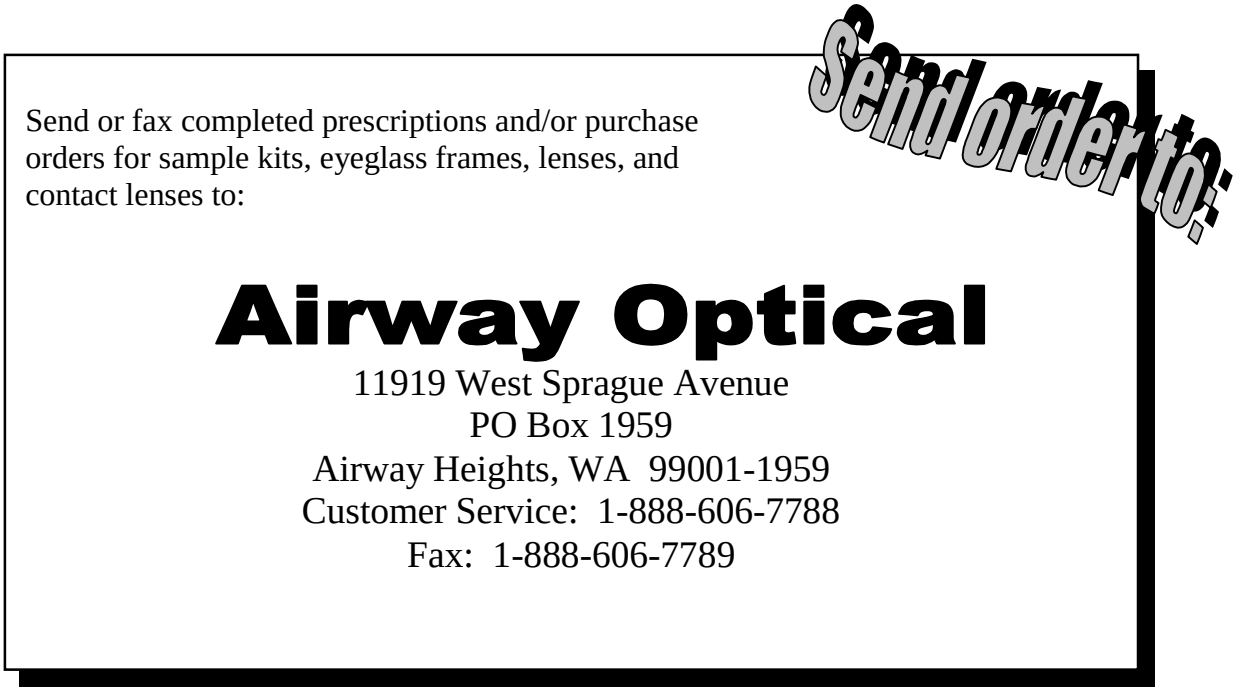
MAA covers surgical procedure s for strabismus (CPT codes 67311-67340) only for clients 17 years of age and younger.

Where and How Do I Order Eyeglasses and Contact Lenses?

Who is MAA's eyeglass contractor?

MAA's eyeglass contractor is Airway Optical (Washington State Department of Correctional Industries).

Eyeglasses and contact lenses, including therapeutic soft contact (bandage) lenses, are covered for eligible Medical Assistance clients only through Airway Optical. No other optical manufacturer or provider will be reimbursed for frames, lenses, or contact lenses.



General Ordering Information

- **Airway Optical will supply prescription order forms upon request.**
  Please call Airway Optical's toll-free number at (888) 606-7788 or fax (888) 606-7789 to order additional forms.

- All prescriptions must be legible and include the prescribing provider's name and return address. The eyeglasses will be mailed to the provider by Airway Optical.

- Providers must mail eyeglass orders, along with a copy of the client's DSHS Medical ID card, to the contractor. Orders and DSHS Medical ID card s may also be faxed. The copy of the Medical ID card must be legible. Keep a copy of the order on file, along with the verification of the fax order.

- DSHS requires Airway Optical to process prescriptions within 10 working days, including shipping and handling time, after receipt of a properly completed order. MAA allows 20 days for completing special orders. Airway Optical must notify the provider when a prescription cannot be processed within either of these specified delivery time frames.

- Include the appropriate diagnosis code on all order forms for eyeglass and contact lenses. If the appropriate diagnosis code is not included on the form, the contractor is required to reject and return the order.

- The contractor will reject and return an order for an eligible client for whom MAA has already purchased a pair of lenses and/or complete frame within the applicable benefit period (12 or 24 months, as appropriate). Similarly, the contractor will reject an order for contact lenses for an eligible client if MAA has already paid for contact lenses or eyeglasses for that client within the past 12 months.

- To obtain general information, or to inquire about overdue prescriptions, call the contractor at their toll-free number.

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Allergen Immunotherapy

[Refer to WAC 388-531-0950(10)]

Reimbursement for antigen/antigen preparation (CPT codes 95145-95149, 95165 and 95170) are **per dose**.

Service Provided	What should I bill?
Injection and antigen/antigen preparation for allergen immunotherapy	✓ **One injection** (CPT code 95115 or 95117); **and** ✓ **One antigen/antigen preparation** (CPT codes 95145, 95146, 95147, 95148, 95149, 95165 or 95170).
Antigen/antigen preparation for stinging/biting insects	✓ CPT codes 95145-95149 and 95170
All other antigen/antigen preparation services (e.g., dust, pollens)	✓ CPT code 95144 for single dose vials; or ✓ CPT code 95165 for multiple dose vials.
Allergist prepared the extract to be injected by another physician	✓ CPT code 95144
Allergists who billed the complete service procedures (CPT codes 95120-95134) and use treatment boards	✓ One antigen/antigen preparation (CPT 95145-95149, 95165, and 95170); **and** ✓ One injection (CPT code 95115 or 95117).
Physician injects one dose of a multiple dose vial	✓ Bill for the total number of doses in the vial and an injection code
Physician or another physician injects the remaining doses at subsequent times	✓ Bill only the injection service

- Reimbursement for an allergist billing both an injection and either CPT code 95144 or 95165 will be the injection plus the fee of CPT code 95165, regardless of whether CPT code 95144 or 95165 is billed. The allergist may bill an Evaluation and Management (E&M) for conditions not related to allergen immunotherapy.

Psychiatric Services

[Refer to WAC 388-531-1400]

> ☞ **NOTE:** These billing instructions are not for use by Psychologists. Refer to MAA's Psychologist Billing Instructions for a description of the psychology program. To view the billing instructions online, go to http://maa.dshs.wa.gov (click on the Provider Publications/Fee Schedules link).

General Guidelines

- MAA reimburses a maximum of one psychiatric service procedure code per client, per day.

- Psychiatrists must bill using one procedure code for the total time spent on direct client care during each visit. Making inpatient rounds is considered direct client care and includes any one of the following:

  ✓ Brief (up to one hour) individual psychotherapy;
  ✓ Family psychotherapy (CPT code 90847);
  ✓ Group psychotherapy (CPT codes 90853 and 90857);
  ✓ Electroconvulsive therapy (CPT codes 90870-90871); or
  ✓ Pharmacological management (CPT code 90862).

- When performing both psychotherapy services and an E&M service on the same visit, use the appropriate psychiatric procedure code that includes the E&M services (e.g., CPT code 90805 – outpatient psychotherapy with E&M or CPT code 90817 – inpatient psychotherapy with E&M).

- A psychiatrist may bill for a medical physical examination in the hospital (CPT codes 99221-99233) in addition to a psychiatric diagnostic or evaluation interview examination (CPT code 90801 for adults or 90802 for children).

- Physicians (who may or may not be psychiatrists) may bill state-unique code 9089M. This service is described as "certification activities related to an elective admission of clients younger than 21 years of age for inpatient psychiatric care."

- Psychiatric sleep therapy is not covered.

- All E&M codes are subject to MAA's current policies and limitations.

- MAA reimburses psychiatrists for the CPT codes listed in the following tables only when billed in combination with the diagnoses listed in the table. **The diagnosis on the detail line must indicate the specific reason for the visit on the date of service being billed.**

Inpatient Hospital

Inpatient CPT Codes	Must be billed in combination with:
Psychiatric Services	
90816-90819, 90823-90827*, 90845, 90847, 90853-90871, 90899	Any MAA covered diagnosis code in the following range: **290-319.99**
Inpatient	
99217-99239	**Any MAA covered diagnosis codes**
Inpatient Consultation	
99251-99275	**Any MAA covered diagnosis codes**
Case Management	
99371-99373	**All MAA covered diagnosis codes**
***Limited to clients 20 years of age and under. **All inpatient psychiatric services should be coordinated by either the local RSN or the client's managed care plan.**	

Outpatient Hospital

Outpatient Procedure Codes	Must be billed in combination with:
Psychiatric Services	
90804-90807, 90810-90813*, 90845, 90847, 90853-90871, 90899 The above procedure codes (except 90862) are subject to a limit of 12 hours, per client, per calendar year.	Any MAA covered diagnosis code in the following range: **290-319.99**
Outpatient	
99201-99215	**Any MAA covered diagnosis codes** except 290-319.99
Outpatient Consultation	
99241-99245	**Any MAA covered diagnosis codes** except 290-319.99
Emergency Room Consultation	
99281-99288	**All MAA covered diagnosis codes** except 290-319.99
Nursing Facility Services	
99301-99316	**All MAA covered diagnosis codes** except 290-319.99
Domicillary/Rest Home Services	
99321-99333	**All MAA covered diagnosis codes** except 290-319.99
Standby Services	
99360	**All MAA covered diagnosis codes** except 290-319.99
Case Management Services	
99371-99373	**All MAA covered diagnosis codes**
***Limited to clients 20 years of age and under. **Any other outpatient psychiatric services should be coordinated by either the local RSN or the client's managed care plan.**	

Limitations for Inpatient and Outpatient Psychiatric Services:

- MAA does not reimburse for psychiatric procedure codes and E&M procedure codes on the same date of service unless there are two separate visits **and** the diagnoses are completely unrelated.

- MAA limits outpatient psychotherapy and electroconvulsive therapy in any combination to one hour per day, per client, up to a total of 12 hours per calendar year. This includes family or group psychotherapy.

- Family therapy is covered only when the client is present.

- Psychiatric diagnostic interview examinations (CPT codes 90801 and 90802) are limited to one in a calendar year unless a new mental health diagnosis occurs.

- The only psychiatric service MAA reimburses psychiatric ARNPs for is a medication adjustment (CPT code 90862).

- MAA reimburses psychiatrists and psychiatric ARNPs only for procedure codes and diagnosis codes that are within their scope of practice.

- Outpatient psychiatric services are not allowed for clients on the General Assistance (GAU) program, except for medication adjustment (CPT code 90862).

- Individual psychotherapy, interactive services (CPT codes 90810-90813, 90823-90824, 90826-90827) may be billed only for clients age 20 and younger.

Involuntary Treatment Act (ITA)

Physicians may provide psychiatric services under the Involuntary Treatment Act according to the following guidelines:

- Each involuntarily committed person must be examined and evaluated by a licensed physician or psychiatrist within 24 hours of admission or payment will be denied. This evaluation may be used for both treatment purposes and court testimony. Bill admissions through the emergency room using state-unique code 9084M.

- Physicians and psychiatrists may bill for a physical examination (state-unique code 9083M) in addition to CPT code 90801 (for adults) or 90802 (for children).

- A day's rounds along with any one of the following constitutes direct client care: narcosynthesis, brief (half-hour or one hour) individual psychotherapy, multiple/family group therapy, group therapy, chemotherapy, or electroconvulsive therapy.

- Payment will be made if the date of service is within 30 days from the date of detention. An extension form is required after 20 days of care. Extension approvals can be from the Regional Support Network (RSN), as well as the state hospital.

- A court may request another physician or psychiatrist evaluation.

- The ITA form needs to include identification of the county of commitment, as well as some identification (signature or initials) of the County Designee completing the form. The physician or psychiatrist needs to complete Section I of the ITA Patient Claim Information form (DSHS 13-628x). If you need copies of this referral form, mail or fax a written request on letterhead to **DSHS Warehouse**, PO Box 45816, Olympia, WA 98504-5816, or FAX (360) 664-0597.

- MAA reimburses for physician and psychiatrist evaluations and consultations to the court regarding the need for continued involuntary psychiatric hospitalization of a client. Documentation of the time required for actual testimony must be maintained in the client's medical record. Only one court testimony will be paid per hearing. Use the ITA court testimony state-unique codes 9085M through 9087M to bill for time spent doing court testimony.

- Additional costs for court testimony are to be reimbursed from county ITA administrative funds.

- Out-of-state providers or border-area providers are not covered.

Podiatric Services

[Refer to WAC 388-531-1300]

- MAA reimburses podiatrists for procedure codes within their scope of care.

- Routine foot care is paid when a medical condition affecting the legs or feet (such as diabetes or arteriosclerosis obliterans) requires that such care be performed by a M.D., D.O., or podiatrist.

Examples of medical necessity include, but are not limited to:

✓ Limitation of ambulation due to mycosis.

✓ Likelihood that absence of treatment will result in significant medical complications.

- MAA reimburses podiatrists for only the orthotics listed below:

State-Unique Code	Modifier	Description/Limits
1600L	**RT** or **LT**	**Single fabricated orthotic**; MAA allows 2 units per client, per calendar year. Limited to 1 unit per date of service. Do not bill in combination with **1601L**.
1601L	No Modifier	**Pair fabricated orthotic**; Must include fabrication for both right and left. Limited to 1 unit per calendar year. Do not bill in combination with **1600L**.
1602L	**RT** or **LT**	**Impression casting, each foot**; MAA allows 2 units per client, per calendar year. Limited to 1 unit per date of service. Do not bill in combination with **1604L**.
1603L	**RT** or **LT**	**Prefabricated orthotic (attach invoice if over $50.00)**; 2 units per client, per calendar year. Do not bill in combination with **1600L or 1601L**.
1604L	No Modifier	**Impression casting, custom shoes, pair;** Must include impression for both feet. Limited to 1 unit per calendar year. Do not bill in combination with **1602L**.

☞**NOTE:** If the description of the orthotic code indicates the code is for a single orthotic or impression casting of one foot, either modifier RT or LT **must** be included on the claim. Providers **must** use an appropriate procedure code with the word "pair" in the description when billing for fabrications, casting, or impressions of both feet.

- Evaluation and Management (E&M) codes can be billed in addition to orthotics if the E&M services performed are justified and documented in the client's medical records.

- Medicare does not reimburse for orthotics and casting. You may bill MAA directly for those services without submitting a Medicare denial, unless the client's Medical ID card indicates *QMB – Medicare only*, in which case the orthotics and casting would not be covered by MAA.

- Biomechanical evaluation (the evaluation of the foot that includes various measures and manipulations necessary for the fitting of an orthotic) is included in the orthotic fee.

MAA does <u>not cover</u> the following services:

- ✓ Treatment of flat feet; and
- ✓ Treatment of fungal (mycotic) disease is considered routine foot care and is not covered unless medical necessity is documented in the client's chart.

- Local nerve blocks for subregional anatomic areas (such as the ankle and foot) are included in the reimbursement for the surgical procedure and are not reimbursed separately.

- Reimbursement for debridement of nails is limited to a maximum of one treatment in a 60-day period unless documented in the client's chart as medically necessary.

- MAA will reimburse podiatrists for covered, diagnostic, radiologic services of the ankle and foot if the client is examined before the x-ray is ordered. X-rays must be of sufficient quality to ensure ease of diagnosis, must be designated left and/or right, and dated and marked with the client's name for ready identification.

- MAA will not reimburse for the following radiology services:
  - ✓ X-rays for soft tissue diagnosis;
  - ✓ Bilateral x-rays for unilateral condition;
  - ✓ X-rays in excess of two views;
  - ✓ X-rays that are ordered before the client is examined; or
  - ✓ X-rays for any part of the body other than the foot or ankle.

Registered Nurse First Assistants (RNFA)

Registered Nurse First Assistants (RNFAs) are allowed to assist at surgeries within their scope of practice. Use modifier 80 to bill MAA for these services. Current RNFA providers who want to assist at surgeries need to submit their Certification as a Certified Nurse Operating Room (CNOR) from the Certification Board Perioperative Nursing to:

Provider Enrollment
PO Box 45562
Olympia, Washington 98504-5562

New RNFA providers must meet the following criteria:

- Licensed in Washington State as a Registered Nurse in good standing;
- Work under the direct supervision of the performing surgeon; and
- Submit the following documentation to MAA along with the Core Provider Agreement:

    - Certification as a Certified Nurse Operating Room (CNOR) from the Certification Board Perioperative Nursing;
    - Proof of Allied Health Personnel privileges in the hospital where the surgeries are performed; and
    - Certification as a RNFA from the Certification Board of Perioperative Nursing.

RNFAs who are current providers or who wish to bill only for cesarean sections (CPT codes 59514 and 59620) **do not need** to submit the Certification as a RNFA from the Certification Board Perioperative Nursing.

Radiology Services

[Refer to WAC 388-531-1450]

General Limitations on Radiology Services

The following services are not usually considered medically necessary and may be subject to post-pay review:

- X-rays for soft tissue diagnosis;
- Bilateral x-rays for a unilateral condition; and
- X-rays in excess of two views.

Contrast Material

Separate payment will not be made for contrast material (A4647) except in the case of low-osmolar contrast media (LOCM) used in intrathecal, intravenous, and intra-arterial injections for clients with one or more of the following conditions:

- A history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting.
- A history of asthma or allergy.
- Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension.
- Generalized severe debilitation.
- Sickle cell disease.

To bill for LOCM, use the appropriate HCPCS procedure code A4644, A4645 or A4646. The brand name of the LOCM and the dosage must be documented in the client's record.

Radiopharmaceutical Diagnostic Imaging Agents

When performing nuclear medicine procedures, separate payment is allowed for radiopharmaceutical diagnostic imaging agents. See procedure codes listed in Section K.

Outpatient MRIs

You must bill using MAA's Expedited Prior Authorization (EPA) process for all outpatient MRIs. See Section I.

Outpatient PET Scans

Effective for dates of service on and after July 1, 2002, Expedited Prior Authorization (EPA) criteria are established for many Positron Emission Tomography (PET) scan codes, allowing providers to create their own prior authorization numbers. Therefore, these covered PET scans no longer require written/fax prior authorization. For details on creating EPA numbers for PET scans, refer to Section I.

> **Exception:** PET scan HCPCS codes G0030-G0047 still require written/fax prior authorization.

MAA no longer accepts the CPT codes for PET scans (codes 78608-78609, 78459, and 78491-78492). Providers **must** use one of the HCPCS codes from the range G0030-G0047, G0125, G0210-G0218, G0220-G0234, and G0253-G0254 when billing for PET scans.

> **Exception:** PET scan CPT code 78810 may be used after written/fax prior authorization has been obtained and **only** when there is no other appropriate HCPCS code to describe the procedure being performed.

HCPCS code G0219 (PET imaging whole body, full- and partial-ring PET scanners only, non-covered individual) **is no longer covered**.

Effective for dates of service on and after July 1, 2002, the following PET scan HCPCS codes are added:

HCPCS Procedure Code	Full Description	MAA Maximum Allowable Fee	Limitations
G0252	PET imaging, full and partial-ring PET scanners only, for initial diagnosis of breast cancer and/or surgical planning for breast cancer (e.g. initial staging of axillary lymph nodes), not covered by Medicare	Not Covered	Not Covered
G0253	PET imaging for breast cancer, full and partial ring PET scanners only, detection of local regional recurrence or distant metastases, i.e. staging/restaging after or prior to course of treatment	By Report	Requires EPA
G0254	PET imaging for breast cancer, full and partial-ring PET scanners only, evaluation of response to treatment, performed during course of treatment	By Report	Requires EPA

Mammograms

MAA has adopted the National Cancer Institute (NCI) recommendations regarding screening mammograms, CPT code 76092. For clients age 40 and over, one annual screening mammogram is allowed. Other screening mammograms may be allowed if determined medically necessary and documented in the client's record.

Radiology Modifiers for Bilateral Procedures

- Bill the procedure on two separate lines using modifier 50 on one line only.
- Bill **modifier LT or RT** on separate lines when a radiological procedure is performed on the right and/or left side or extremity.
- Do not use modifier 50, LT, or RT, if the procedure is defined as bilateral.

Anesthesia for Radiological Procedures **[Refer to WAC 388-531-0300 (2) and (7)]**

General anesthesia will be allowed for radiological procedures for children and/or non-cooperative clients when the medically necessary procedure cannot be performed unless the client is anesthetized.

Providers **must** use the anesthesia CPT code 01922 when providing general anesthesia for non-invasive imaging or radiation therapy. **Do not** bill the radiological procedure code with an anesthesia modifier to bill for the anesthesia procedure.

When using CPT code 01922 for non-invasive imaging or radiation therapy:

- ✓ The client must be 17 years of age or younger; **or**
- ✓ A statement of the client-specific reasons why the procedure cannot be performed without anesthesia services must be kept in the client's medical record and made available to MAA on request.

Nuclear Medicine

When billing MAA for nuclear medicine, the multiple surgery rules will be applied when:

- The coding combinations listed below are billed:

  ✓ For the same client, on the same day, by the same physician or by more than one physician of the same specialty in the same group practice; or
  ✓ With other codes that are subject to the multiple surgery rules, not just when billed in the combinations specified below.

  - CPT code 78306 (bone imaging; whole body) and 78320 (bone imaging; SPECT);
  - CPT code 78802 (radionuclide localization of tumor; whole body) and 78803 (tumor localization; SPECT); and
  - CPT code 78806 (radionuclide localization of abscess; whole body) and 78807 (radionuclide localization of abscess; SPECT).

Consultation on X-Ray Examination

- When billing a consultation, the consulting physician must bill the specific radiological x-ray code with modifier 1R (professional component).

  For example: The primary physician would bill with the global chest x-ray (CPT code 71020) or the professional component (CPT codes 71020-26), but the consulting physician would bill only for the chest x-ray consultations (e.g., 71020-1R).

Portable X-Rays

- Portable x-ray services furnished in clients' homes or nursing facilities are limited to the following tests:

  ✓ Skeletal films involving extremities, pelvis, vertebral column, or skull;
  ✓ Chest or abdominal films that do not involve the use of contrast media; or
  ✓ Diagnostic mammograms.

- To bill for transportation of equipment, bill either HCPCS code R0070 (one patient, one unit) or HCPCS code R0075 (multiple patients, multiple units).

Pathology and Laboratory

[Refer to WAC 388-531-0800 and WAC 388-531-0850]

Certification

Independent laboratories must be certified according to Title XVII of the Social Security Act (Medicare) to receive payment from Medicaid.

MAA reimburses laboratories only for MAA-certified tests.

CLIA Certification

All facilities performing laboratory testing must have a Clinical Laboratory Improvement Amendment (CLIA) certificate and identification number in order to receive reimbursement from MAA. Your claim for laboratory services cannot be paid unless your active CLIA identification number is on file with MAA.

To obtain CLIA certificate and number, or to resolve questions concerning your CLIA certification, call (206) 361-2802 or write to:

Department of Health
Office of Laboratory Quality Assurance
1610 NE 150th Street
Seattle, Washington 98155-9701
(206) 361-2802 or (206) 361-2813 FAX

Referenced Laboratory

If a laboratory sends a specimen to a referenced lab, you may bill for the referenced lab. However, the referenced lab provider number must be entered in the performing provider's number field. The referenced lab must be CLIA certified and have an active CLIA identification number on file with MAA. Use modifier 90.

NOTE: Providers, please remember that laboratory claims must include an appropriate diagnosis code. The ordering provider must give the diagnosis code to the performing laboratory at the time the tests are ordered. MAA will not reimburse a laboratory for procedures without an appropriate diagnosis code.

Cancer Screens (HCPCS codes G0101-G0107 and G0120-G0122)

HCPCS Code	Coverage Restrictions	Allowed Only With Diagnosis Code(s)
G0101	Females only	V76.2
G0102	Bundled	
G0103	Males age 50 and older Once every 12 months	Any valid ICD-9 code other than high risk
G0104	Clients age 50 and older Allowed once every 48 months	Any valid ICD-9 code Other than high risk
G0105	Clients at high risk for colorectal cancer One every 24 months	High risk* 555.1, 555.0, 555.2, 555.9, 556.0-556.6, 556.8, 556.9, 558.2, 558.9 V10.05, V10.06, V12.72, V16.0
G0106	Clients age 50 and older and not a high risk Once every 48 months	Any valid ICD-9 code Other than high risk
G0107	Clients age 50 and older Once every 12 months (1-3 simultaneous determinations)	Any valid ICD-9 code Other than high risk
G0120	Clients age 50 and older who are at high risk for colorectal cancer Once every 24 months	High risk* 555.1, 555.0, 555.2, 555.9, 556.0-556.6, 556.8, 556.9, 558.2, 558.9 V10.05, V10.06, V12.72, V16.0
G0121	Once every 48 months	Any valid ICD-9 code Other than high risk
G0122	None	Any valid ICD-9 code Other than high risk

MAA does **not cover** diagnosis codes V16 and V28.9.

* Allowable diagnoses have changed in accordance with Medicare's guidelines.

Coding and Payment Policies

Pathology and laboratory services must be provided either by a pathologist or by technologists who are under the supervision of a physician.

- Physicians must bill using their provider number for laboratory services provided by their technicians under their supervision.
- An independent laboratory and/or hospital laboratory must bill using its provider number for any services performed in its facility.
- MAA will reimburse for one blood draw fee (CPT code 36415 or 36540) per day.
- MAA will reimburse for one catheterization for collection of a urine specimen (HCPCS code P9612) per day.
- CPT codes 85007, 85009, 85014, 85018, 85021, 85027, 85041, and 85048 are included in the complete blood count procedure.
- CPT codes 81001, 81002, 81003 and 81015 are not allowed in combination with urinalysis procedure 81000.
- CPT codes 86812-86822 are limited to a maximum of 15 tests total for human leukocyte antigens (HLA) typing per client, per lifetime.
- Do not bill with modifier 26 if the description in CPT indicates professional services only.
- Reimbursement for lab tests includes handling, packaging and mailing fee. Separate reimbursement is not allowed.
- For **modifier 91**, see page E20.

Drug Screens

- MAA will reimburse for drug screens only when medically necessary and when ordered by a physician as part of a medical evaluation or when required drug and alcohol screens to assess suitability for medical tests or treatment.

- MAA will not reimburse for screens to monitor any of the following:

  ✓ Program compliance in either a residential or outpatient drug or alcohol treatment program;
  ✓ Drug or alcohol abuse by a client when performed by a provider in a private practice; or
  ✓ To monitor suspected drug use by clients in a residential setting such as a group home.

- For clients in the DASA contracted methadone treatment programs, drug screens are reimbursed through a contract issued by DASA, not through MAA.

Laboratory Services Referred by Community Mental Health Center (CMHC) Providers or Alcohol & Substance Abuse Providers

When CMHC or Alcohol & Substance Abuse providers refer Healthy Options clients for laboratory services, the laboratory must bill MAA directly, and the following conditions apply:

- The laboratory service is medically necessary;
- The laboratory service is directly related to the client's mental health or alcohol and substance abuse needs
- The laboratory service is referred by a CMH provider who has a core provider agreement with MAA; and
- The laboratory must bill with a mental health, substance abuse, or alcohol abuse diagnosis.

To bill for laboratory services, laboratories **must** put the seven-digit CMHC or Division of Alcohol and Substance Abuse (DASA) referring provider identification number assigned by MAA in **field 17a** on the HCFA-1500 claim form.

Direct entry and electronic billers must use the appropriate field.

Automated Multi-Channel Tests

MAA will reimburse for:

- CPT lab panel codes 80048, 80050, 80051, 80053, 80061, 80069, 80072, and 80076. The 22 individual automated multi-channel tests are:

Procedure Code	Description
82040	Albumin; serum
82247	Bilirubin; total
82248	Bilirubin; direct
82310	Calcium; total
82374	Carbon dioxide (bicarbonate)
82435	Chloride; blood
82465	Cholesterol, serum, total
82550	Creatine kinase (CK)
82565	Creatine; blood
82947	Glucose; quantitative
82977	Glutamyltransferase, gamma (GGT)
83615	Lactate dehydrogenase (LD),(LDH)
84075	Phosphatase, alkaline
84100	Phosphorous inorganic (phosphate)
84132	Potassium; serum
84155	Protein; total, except refractometry
84295	Sodium; serum
84450	Transferase; apartate amino (AST)(SGOT)
84460	Transferase; alanine amino (AST)(SGPT)
84478	Tryglycerides
84520	Urea nitrogen; quantitative
84550	Uric acid; blood

- You may bill a combination of panels and individual tests. <u>However, do not bill separately for any individual tests that are included in the panel.</u> Duplicate tests will be denied. Panel codes must be billed if all individual tests in the panel are performed.

- Each test and/or panel must be billed on a separate line.

- All automated/non-automated tests must be billed on the same claim form when performed for a client by the same provider on the same day. For laboratory services that exceed the lines allowed per claim, see the next page:

Billing for laboratory services that exceed the lines allowed

- Providers who bill on hardcopy HCFA-1500 claim forms are allowed up to 6 lines per claim. Direct entry, magnetic tape, and electronic submitters are allowed 21 lines per claim. **Use additional claim forms, if the services exceed the lines allowed.** Note the statement "additional services" in field 19 on the HCFA-1500 claim form or in the *Remarks/Comments* area, when billing electronically. MAA will review the claims for correct payment. *Total* each claim separately.

- If MAA pays a claim with one or more automated/non-automated lab test, bill any additional automated/non-automated lab tests for the same date of service on a blue Adjustment Request form (DSHS 525-109). Make sure you adjust the claim with the paid automated/non-automated lab tests, using the comment "additional services."

If all services for **automated/non-automated lab tests** for the same date are denied, then follow the instructions in the first bullet on this page. If multiple claims are necessary and you are submitting on the HCFA-1500 paper claims, add the statement **additional services in box 19.**

For individual automated multi-channel tests (see previous page for list), providers will be paid on the basis of the total number of individual automated multi-channel tests performed for the same patient, on the same day, by the same laboratory. Each test must be billed as a separate line item on the claim form if:

1. Not all the procedures in a panel are performed;
2. There are additional automated multi-channel tests not included in a panel; or
3. There are other individual tests.

Reimbursement is based on the total number of tests.

For example:

- If five individual automated tests are billed, the reimbursement will be equal to the updated internal codes maximum allowable fee.

- If five individual automated tests and a panel that contains automated tests are billed, reimbursement will be the maximum allowable for the panel. Reimbursement for the individual tests, less any duplicates, will be equal to the internal codes maximum allowable fee.

If one automated multi-channel test is billed, reimbursement will be at the individual procedure code or internal codes maximum allowable fee, whichever is lower. The same will apply if the same automated multi-channel test is performed with modifier 91. (See page E20 for information on modifier 91.)

Non-automated Multi-Channel

Organ and Disease Panels, CPT codes 80055, 80074, and 80090 do not include automated multi-channel tests. If all individual tests in the panel are not performed reimbursement will be at the individual procedure code maximum allowable fee or billed charge, whichever is lower.

The 19 non-automated multi-channel tests are:

CPT Code	Description
83718	Assay of lipoprotein
84443	Assay thyroid stim hormone
85022	Automated hemogram
85025	Automated hemogram
85651	Rbc sed rate, nonautomated
86255	Fluorescent antibody, screen
86430	Rheumatoid factor test
86592	Blood serology, qualitative
86644	CMV antibody
86694	Herpes simplex test
86705	Hep b core antibody, test
86709	Hep a antibody, igm
86762	Rubella antibody
86777	Toxoplasma antibody
86803	Hep c ab test, confirm
86850	RBC antibody screen
86900	Blood typing, ABO
86901	Blood typing, Rh(D)
87340	Hepatitis b surface ag, eia

Laboratory Modifiers

Modifier QP

Modifier QP indicates documentation is on file showing that the lab test(s) was ordered individually or ordered as a CPT recognized panel other than automated profile codes. This modifier is used ***for information only.*** **This modifier is <u>not</u> appropriate to use for billing repeat tests or to indicate not done as a panel.**

Modifier 90

- **<u>Reference (Outside) Laboratory</u>**: when a lab other than the referring lab performs laboratory procedures, the procedure must be identified by adding modifier 90 to the procedure code. *The referenced lab provider number must be entered in the performing number field on the HCFA-1500 claim form or electronic claim record. The referral lab must be CLIA certified.*

Modifier 91

- **Modifier 91 does affect payments**.

- Use this modifier:

  ✓ Only for clinical laboratory tests; and
  ✓ When repeat tests are performed on the same day, by the same provider, to obtain reportable test values with separate specimens taken at different times when it is necessary to obtain multiple results in the course of treatment. **Use modifier 91 with the appropriate procedure code for repeat tests.**

DO NOT USE THIS MODIFIER when tests are rerun:

- To confirm initial results;
- Due to testing problems with specimens or equipment;
- For any reason when a normal, one-time, reportable result is all that is required; **or**
- There are standard HCPCS codes available that describe the series of results (e.g., glucose tolerance test, evocative/suppression testing, etc.).

Justification to bill modifier 91 must be maintained in the client's medical record.

Clinical Laboratory Codes

Nineteen clinical laboratory codes have both a professional component and a technical component. If performing only the technical portion, do not bill with a modifier. (The former TC is the global code in your fee schedule with no modifier.) The professional component for physician interpretation must be billed using modifier 26. Laboratories performing both the professional and the technical components must bill the code without a modifier for the technical and with modifier 26 for the professional. These services may be billed either on separate lines or on separate claim forms. Listed below are the 19 laboratory codes.

Code	Brief Description
83020	Hemoglobin electrophoresis
83912	Genetic examination
84165	Assay of serum proteins
84181	Western blot test
84182	Protein, western blot test
85390	Fibrinolysins screen
85576	Blood platelet aggregation
86255	Fluorescent antibody; screen
86256	Fluorescent antibody; titer
86320	Serum immunoelectrophoresis
86325	Other immunoelectrophoresis
86327	Immunoelectrophoresis assay
86334	Immunofixation procedure
87164	Dark field examination
87207	Smear, special stain
88371	Protein, western blot tissue
88372	Protein analysis w/probe
89060	Exam, synovial fluid crystals
P3001	Screening pap smear, cervical or vaginal, up to 3 smears, requiring interpretation by physician

STAT lab Charges

NOTE: The state-unique procedure code **8949M** for STAT laboratory charges **is discontinued** and **replaced** with **HCPCS code S3600**.

Laboratory services are covered under the RBRVS fee schedule. When laboratory tests are appropriately performed on a STAT basis, the provider may bill **HCPCS code S3600** (Stat laboratory request). Reimbursement will be limited to one STAT charge per episode (not once per test). Tests must be ordered STAT and limited to only those that are needed to manage the patient in a true emergency. The laboratory report must contain the name of the provider who requested the STAT. The medical record must reflect the medical necessity and urgency of the service.

"STAT" Charges

Note: "STAT" must be clearly indicated by the physician and be documented on patient orders or records. Tests generated from the emergency room do not automatically justify a STAT order. Use **HCPCS code S3600** with the following procedure codes.

The STAT charge will be paid only with the tests listed below. Please refer to a CPT book for complete descriptions:

80048	Basic metabolic panel
80051	Electrolyte panel
80069	Renal function panel
80076	Hepatic function panel
80100	Drug screen, qualitate/multi
80101	Drug screen, single
80156	Assay, carbamazepine, total
80162	Assay of digoxin
80164	Assay, dipropylacetic acid
80170	Assay of gentamicin
80178	Assay of lithium
80184	Assay of phenobarbital
80185	Assay of phenytoin, total
80188	Assay primidone
80192	Assay of procainamide
80194	Assay of procainamide
80196	Assay of salicylate
80197	Assay of tacrolimus
80198	Assay of theophylline
81000	Urinalysis, nonauto w/scope
81001	Urinalysis, auto w/scope
81002	Urinalysis, nonauto w/o scope
81003	Urinalysis, auto, w/o scope
81005	Urnalysis
82003	Assay of acetaminophen
82009	Test for acetone/ketones
82040	Assay of serum albumin
82055	Assay of ethanol
82150	Assay of amylase
82247	Bilirubin; total
82248	Bilirubin; direct
82310	Assay of calcium
82330	Assay of calcium
82374	Assay, blood carbon dioxide
82435	Assay of blood chloride
82550	Assay of ck (cpk)
82565	Assay of creatinine
82803	Blood gases: pH, pO2 & pCO2
82945	Glucose other fluid
82947	Assay, glucose, blood quant
83615	Lactate (LD) (LDH) enzyme
83663	Test urine for lactose
83664	Lamellar bdy, fetal lung
83735	Assay of magnesium
83874	Assay of myoglobin
84100	Assay of phosphorus
84132	Assay of serum potassium
84155	Assay of protein
84295	Assay of serum sodium
84450	Transferase (AST)(SGOT)
84484	Assay of troponin, quant
84512	Troponin qualitative
84520	Assay of urea nitrogen
84550	Assay of blood/uric acid
84702	Chorionic gonadotropin test
85007	Differential WBC count
85021	Automated hemogram
85022	Automated hemogram
85023	Automated hemogram
85024	Automated hemogram
85025	Automated hemogram
85027	Automated hemogram
85046	Automated hemogram
85378	Fibrin degradation
85384	Fibrinogen
85595	Platelet count, automated
85610	Prothrombin time
85730	Thromboplastin time, partial
86308	Heterophile antibodies
86403	Particle agglutination test
86880	Coombs test
86900	Blood typing, ABO
86901	Blood typing, Rh (D)
86920	Compatibility test
86921	Compatibility test
86922	Compatibility test
86971	RBC pretreatment
87205	Smear gram stain
87210	Smear, wet mount, saline/ink
87281	Pneumocystis carinii, ag, if
87327	Cryptococcus neoform ag, eia
87400	Influenza a/b, ag, eia
89051	Body fluid cell count

Pap Smears

- Use CPT codes 88147-88154 and 88164-88167 for conventional Pap Smears.

- MAA reimburses for thin layer preparation CPT codes 88142-88145. HCPCS codes G0123-G0124, and G0141-G0148 remain non-covered. MAA reimburses for thin layer paps at Medicare's payment levels. Thin layer preparation and conventional preparation CPT codes cannot be billed in combination.

- Use CPT codes 88141 and 88155 in conjunction with codes 88142-88154 and 88164-88167.

HIV Testing

- The state-unique code for HIV virtual phenotype, **8999M** has been deleted and replaced with the following HCPCS code, and will be paid By Report:

HCPCS Code	Brief Description
0023T	Phenotype drug test, HIV 1

- The CPT codes for HIV testing 87534, 87535, 87536, 87537, 87538, and 87539 are restricted to ICD-9 diagnoses 042 or V08.

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